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MEDICARE REFORM
The National and New Mexico Impact

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BEFORE THE

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MEDICARE REFORM
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WEDNESDAY, FEBRUARY 15, 1984

U.S. SENATE,
COMMITTEE ON THE BUDGET,
Albuquerque, N. Mex.

The committee met, pursuant to notice, at 9:38 a.m., in the auditorium of the Family Practice Building, University of New Mexico Medical School, Albuquerque, N. Mex., Hon. Pete V. Domenici (chairman) presiding.

Present: Senators Domenici and Durenberger.

Staff present: Tony McCann, analyst for health programs.

Chairman DOMENICI. We are going to try to stay on schedule. We are about 5 minutes late. Let me open with a few remarks and yield to my friend from Minnesota. Then we will have Jeff Bingaman's staff person, since Jeff is unable to attend, give us some opening remarks, and we will proceed with the schedule.

OPENING STATEMENT OF CHAIRMAN DOMENICI

First, I would like to welcome a very distinguished colleague, Senator David Durenberger, to our city and these hearings. I am particularly pleased that Senator Durenberger, who chairs the Health Subcommittee of the Finance Committee, was able to find time in his busy schedule to attend this hearing.

MEDICARE IN TROUBLE AND OUT OF CONTROL

Senator, I am sure you will remember when the administration came to power and our party took over the Senate. Medicare spending clearly, under anyone's definition, was out of control, and we were in big trouble. Between 1976 and 1981 medicare was growing at an annual rate of 18 percent a year. The hospital insurance portion of that grew at 17.4 percent, while the medical insurance grew at 19.6 percent, almost 20 percent.

Now, inflation was rather high at some portions of the period that I have described. But while inflation has come down, the growth in that program has moderated some—and I will give you a few numbers—but it is still rather frightening.

A modest $2.3 billion reduction was enacted under the leadership of Senator Long in 1980. By 1982 it was clear that reforms were needed in medicare if the program was going to avoid bankruptcy as early as 1983 and 1984. So I want to compliment you,

Senator, because under your leadership, and that of Senator Dole and others, additional reformation in the medical hospital reimbursements have occurred and no longer will medicare provide incentives to spend money by raising costs. Rather, a set fee was established for each of the 467 separate procedures—giving hospitals an incentive to reduce costs.

Obviously, one of the reasons we are excited about this hearing and the excellent witnesses we are going to have is that we are going to get their views of what might happen before it happens. We don't know exactly how all this is going to work, and we are going to hear from some people down the line with reference to the changes that have been imposed by Congress.

When these changes occurred, we already knew that New Mexicans were quick to respond with some very innovative ideas in different ways. The reforms have contributed to basic changes in our Nation's basic health care system, and I think it is fair to say that New Mexico remains on the cutting edge of this change and this movement.

Blue Cross and Blue Shield is changing the way it reimburses hospitals to provide incentives to reduce costs. Again, that is their goal. Before the day is out, we will probably find out how those that they are reacting with think these changes are going to come out.

Hospitals are restraining costs through new and different techniques. New ways of providing care are being devised such as urgent care centers, which are growing not only here but apparently it is a very broad change in the delivery system.

Organizational changes, where hospitals and doctors band together to reduce costs, either have occurred or are in the works. These preferred provider organizations are developing across the country. Our State, once again, seems to be on the cutting edge. The impact of this change, and other smaller ones, has been very dramatic. Growth in the hospital insurance portion of medicare has declined from 17.9 percent per year, prior to 1981, to 11.9, almost 12, between 1984 and the prediction is up through 1989.

SHARING THE BURDEN OF REFORM

In the next 5 years, these reductions will save that fund about $11.3 billion. This reduction has been achieved through a sharing of the burden of reform, the way that most reforms are achieved in this country. During the 1981–83 period, 51 percent of the reductions were achieved by provider reimbursement changes, most of which dealt with hospitals. Another 25 percent were achieved by expanding coverage of the programs, and about 23 percent were achieved through increases in the cost to the beneficiaries. The medicare problem is not solved. What we have done is postpone the inevitable, that is an actual deficiency in the fund versus the claims. Some people call that bankruptcy. We have delayed that, although it still looms. Our best estimate is that it is out about 1990 now.

The immediate concerns on the horizon are the rapid growth of the supplemental medical insurance portion of medicare. While the hospital insurance portion is growing at a declining rate, the sup-

plemental medical insurance portion continues at close to its 1981 levels, and the Federal contribution will double between 1984 and 1986, amounting to over $34 billion by that time.

We have made changes in the hospital reimbursement which are just beginning to take effect. I am not an expert. Senator Durenberger and his subcommittee are the ones who are charged with making the changes. We have talked at length. And even though many indications are there that the reforms will work, obviously we are interested in hearing from those who are on the frontlines.

PRESSURE APPLIED TO HOSPITAL OVERUTILIZERS

I think you have all noticed the recent Wall Street Journal article that stated that hospitals have begun to apply pressures on those who overutilize facilities. Insurers are changing their methods of reimbursement. In the early months of this fiscal year, hospital insurance outlays were only growing at 10 percent. That is below the policy projection lines that were assumed in the budgets. A recent episode of Frontline on PBS indicated that indigent patients are having greater difficulty in obtaining needed care. We want to hear about that, and we will, before the day is out; and we will meet with hospital administrators for lunch in an informal setting to get more specific ideas and more detailed discussions between Senator Durenberger and myself and them.

The purpose of the hearing, as we understand it, is to help identify the early indications of the impact of these reforms and to help us learn how New Mexico has responded to it. We have the leadership in the medical delivery system of New Mexico to tell us what they think is going to happen as a result of the changes and the other things that they can predict at this point which we ought to know about. We have very distinguished witnesses. We are going to have most of them in panels.

We are going to open up with a national overview. After the opening remarks, then we will go to the panels.

Senator Durenberger, I am delighted to yield now to you. I personally want to thank you for joining us.

OPENING STATEMENT OF SENATOR DURENBERGER

Senator DURENBERGER. Thank you. I thought I would get back to New Mexico to get my battery warmed up. I might as well have stayed in Minnesota, except for the fact that I am chairman of the Health Subcommittee of the Finance Committee, and have all the responsibility for the medicare and medicaid and related programs in the Social Security Act. I have found that Washington is not the place to learn anything, other than how brilliant your colleagues are and how hard they work.

This past weekend I started in Utah, then moved on to California, and now am here doing this sort of thing, just listening to the kind of people whom we are going to have an opportunity to hear from today. Pete has done an excellent job in reviewing some statistics which illustrate our problems in medicare, what we have done about some of those problems, and what our opportunities are out ahead, but they are the kinds of problems that catch a budget-cutter's eye.

MEDICARE FASTEST GROWING PART OF ECONOMY

So Pete is one of those people, because he has to come at this entire process from the budget, who has achieved a sense of substance in each of the areas of public policy. This is the one which, believe it or not, despite what you read about in defense, this is the area that is growing faster than any other part of our economy. This is the one that now takes about 10.5 percent of our gross national product. This is the one where the costs double every 5 years in the public and private sector. And this is the one in which people's lives and well-being are directly at stake every day, not just in case we go to war again, but every single day. So it is the one on which Pete and I have spent a great deal of time.

REGULATION NOT THE KEY TO LOWER COSTS

Now there are some politicians who propose that we solve this problem with regulation. They have been around a long time. It used to be called hospital cost containment. It was originally called certificate of need, and a variety of things like that, but the essence of their approach is regulatory. The Government says, "This is what you do, and this is what people are getting paid." Senator Teddy Kennedy and Representative Gephardt on Monday of this week came with a new version of this regulatory process. They set prices for hospital services provided to all patients and it is all very politically attractive.

When I was at the American Association for Retired Persons' legislative meeting last week, they said, "80 percent of our members think we should put a cap on what doctors and hospitals and everybody else are paid, and that would be the way to solve the problems." Politically that sounds good.

In our country for the last 100 years we have done a lot of that. First we did it in the railroads, because the railroads were ripping off the country. So we created the Interstate Commerce Commission. We said, "You can only make so much money to go from here to there." In effect, we killed off railroads.

Chairman DOMENICI. We told them what routes they could keep.

Senator DURENBERGER. We told them what commodities and what price they could charge. We did it for trucking. In effect, what we did for all these areas is give certain people a franchise. Nobody else could get in the business. I moved from Minnesota to Washington. First, I discovered that there weren't any perks to being a Senator. I thought somebody would pay to move my family. Nobody paid to move my family. I had to pay it myself. The second discovery, when I went to find a moving company, is I couldn't select one out of the bunch, because it would cost $5,000 no matter who moved me. How could I use price as a leverage?

COMPETITION THE WAY TO HOLD PRICES DOWN

Well, that is in essence what the regulators would do with the health care industry. I think the best way to keep costs down—and we have been doing this in Minnesota, you can see it in New Mexico and you can see it in California. The best way in the long run to keep costs down is to restore the opportunity, and the incen-

tives, for consumers and providers of health care, to have consumer choice in health care. And out of that you will get price competition among hospitals and physicians.

In California, where I had hearings like this the last 2 days, you talk about HMO's and PPO's and private insurance receivers all scrambling around for business. You can't even keep track of it in California. In Minnesota, you talk about the effect of some of these things. I was telling him earlier that doctors are now making house calls again. They are having evening hours. They are having weekend hours. They want people's business. There is quite a change in a relatively short period of time.

We have engaged in some legislating in this area. And then all of the legislating has not been miracle legislating, but mainly facilitating change. The DRG's that Pete spoke of, right now they are only for hospitals. Within the next year or two—in the next year, I predict—they would provide all providers, even physicians, the diagnostic related grouping prospective payment system, skilled nursing facilities for home health, and for physicians, one single payment covering all services.

But that isn't really the ideal for the end. The end is a voucher program of some kind where every medicare beneficiary gets a plan from the Government and they go out and shop with that plan. You get the Government out of the business of deciding how much this doctor is going to get paid and how much that one is going to get paid. In Minnesota, we have that working. We have 30,000 senior citizens who are shopping with a voucher. They have reduced their personal costs by 50 percent and they have reduced medicare costs in those areas by 30 percent. So choice does work in this system and it works so much better than the alternative.

It also has other benefits. I am staying in a hotel that passes out the Wall Street Journals for free, unless it shows up on my bill. This morning on the back page is, "Medical to close its manufucturing line as CAT scan sales fall." To me, that is good news. You may think that we are getting rid of CAT scan. This is good news. It just says that we aren't passing out million-dollar equipment like it was for free.

NEW WAYS OF PROVIDING CARE INCREASING

But the interesting thing that is happening with all of this high-cost technology—which we need, but we don't need to have spread around in every room in every hospital—is while those things are declining, changes in the way people provide health care are increasing. There are more variations on home health care than ever before. There are more variations on community-based health care services than you have ever seen before—a lot of nonprofit changes.

And I think Presbyterian here is hooked up with a national association of people that are doing very innovative things in health care delivery in trying to suit services to customers, or consumers, if you will. So I guess I am here to listen to how the marketplace can work. Pete, I appreciate very much your having this hearing, which gives me the opportunity to learn from your constituents.

Chairman DOMENICI. Thank you very much.

STATEMENT OF SENATOR BINGAMAN

Chairman DOMENICI. Rebecca Bustamante represents Senator Bingaman, who could not be here, who would like to give an opening statement for the Senator.

Ms. BUSTAMANTE. Thank you very much. Senator Bingaman is really happy to participate in this oversight hearing on medicare reform, and its impact in New Mexico and nationwide is most timely. Thanks to the good work of medical researchers, practitioners, and administrators, we have seen much suffering from many diseases wiped out. But it has been at an extremely high cost.

The astronomical rise in the cost of health care is well known to all of us. And the burden of these costs have been borne by all of us: By private citizens whose monthly insurance payments take ever-larger bites out of their income; insurance companies who can no longer balance their rising costs with the public outcry to hold down premiums; hospitals and doctors whose costs continue to escalate along with pressures from all sides to hold prices down; and certainly the State and Federal Governments, and the taxpayers who generate the revenues.

RISING COSTS TRIGGER LEGISLATION

Congressional concerns with these mushrooming costs and with the soundness of medicare has triggered two important legislative initiatives—the Tax Equity and Fiscal Responsibility Act of 1982 and the Social Security Amendments of 1983.

Under the new reforms embodied in these initiatives, hospitals will no longer be reimbursed for inpatient services provided at cost. Rather, reimbursements will be based on individual patient diagnosis. This prospective payment system is based on a set of diagnosis related groups which classify patients into groups by diagnosis.

In my opinion, Mr. Chairman, I consider the PPS/DRG alternative a positive one. If it is administered properly, cuts in Federal outlays, which increase out-of-pocket expenses for medicare patients and push up costs for medicaid, would be held to a minimum. The reforms, therefore, have important long-range implications for us all, including those concerned about the Federal budget deficit and those concerned about quality, affordable, health care.

CONCERNS ABOUT REFORMS

However, I do have some concerns. I am concerned about the effect of the DRG system on the accessibility and quality of health care. Some predict that patients would be discharged prematurely under the DRG system. Others predict that readmissions would increase. The hospitals would use the cheapest rather than the most effective drugs, or that needed tests would be skipped to save the hospitals money. Some skeptics say that the DRG 468 is an open invitation to abuse and will allow hospitals to "game" the system for up to $218 million in fiscal 1984. These may be valid concerns.

I am also concerned about the future of hospital-based home health care agencies. From December 1978 to the end of November 1983, the number of medicare certified hospital-based agencies grew by 77 percent, from 319 to 566. Hospital-based agencies as of

November 30, 1983, now represent about 14 percent of all medicare-certified home health agencies, compared to about 11 percent at the end of 1978. These are one of the fastest growing types of home health care agencies.

Skeptics predict that the DRG system will further accelerate the trend of hospitals to either establish their own home health agencies--individually or through joint arrangements—or to develop closer ties to existing freestanding agencies. What preparation have we made for this increase in home health care agencies? Are we planning any assistance in defining terms such as "skilled visits" and "homebound"? Is there also going to be a struggle as to what home health care agencies can offer their sicker patients?

Mr. Chairman, I recognize that health care in America has come full circle. Health care originally started in the home and moved to the hospital with the advent of technology and improved diagnostic and treatment methodologies. Now a new emphasis is being placed on the home setting to help control costs. Because care in the home is becoming more accepted, primarily because of restricted reimbursement for inpatient care, an attractive market is developing. Others in the Senate have recognized this, too. Senators John Heinz and Lloyd Bentsen will introduce the Home Health Care Protection Act when the Senate reconvenes on February 20. I have agreed to become an original sponsor of this bill and I support its prompt consideration and passage.

The Home Health Care Protection Act represents a modest response to those complaints received from individuals who operate home health agencies, and beneficiaries who should be receiving medical attention at home, but who are precluded because of restrictive interpretation by an agency of the Federal Government.

Home health benefits were first provided for under the medicare provisions in 1965. Section 1861(m) of the Social Security Act defined home health services covered by medicare as items and services furnished to a beneficiary at home under physician's plan of treatment. It included part-time or intermittent care under the supervision of a registered professional nurse. The law also says home care includes "skilled nursing care on an intermittent basis." Controversy began when the HCFA narrowly interpreted the word "intermittent." Congress intended to use this language to counterpoint its coverage of skilled nursing care in a nursing home. To qualify for nursing home care paid by medicare, Congress said that an individual must need full-time nursing care.

Congress intended that deference be accorded the physician's judgment. Payment for home care visits under medicare can only be made when services are delivered in line with a plan of treatment established and periodically reviewed by a physician. Moreover, it is the physician who must determine the first instance, and on an ongoing basis, whether the patient should receive part-time nursing services in the home or full-time nursing services in a hospital or skilled nursing home. Where a noninstitutional level of care is considered appropriate by a physician and home health care visits are not full time in scope, the medicare statute requires coverage

This problem has been called to my attention by many here in New Mexico. With all the talk about saving money, we must not

neglect the main point: What is happening to the people? What will happen to those who are not sick enough to be admitted to the hospital and yet need medical attention in a home setting? Will they need more visitations by a skilled nurse than the law allows? I have two examples here. One of them is a 93-year-old patient who, if he would be able to get this kind of service at home, it could cost about $4,805. Because he can't get it through a home health agency, he is on a waiting list to go in a nursing home at a cost of about $14,200 per year.

These problems are not just New Mexico problems, they are national problems. The National Association for Home Care representing home health and hospice interests, has developed evidence of existing severe problems in 15 States. Legislation would clarify the term "intermittent care" and focus congressional attention on these problems. As I have stated, the bill would specify that a person otherwise qualifying for home care under medicare would be entitled to up to 60 days of daily visits under each bout of illness. This is a reasonable solution that is most beneficial to the patient and least costly to the taxpayer.

I wish to thank you for the opportunity to express my interest in these matters. I commend you for holding a meeting so important to our daily lives and for the leadership you are giving on this sensitive matter. Thank you.

Chairman DOMENICI. Thank you very much. We are delighted to have you. Thank the Senator for sending you.

Ms. BUSTAMANTE. Thank you.

MORE SPENT ON MEDICARE THAN EVER

Chairman DOMENICI. Let me call our first witness: Deputy Assistant Secretary Robert B. Helms. He is in charge of Planning and Evaluation/Health, for the U.S. Department of Health and Human Services. It is a delight to have you here with us today. We have your prepared testimony. It will be made a part of the record. We would like you to keep your opening remarks to 10 minutes, if possible, and then answer questions. Even though most of you are well-informed, and I am almost tempted to have a quiz, I won't. How much did we spend on medicare in 1981, and how much will we spend by the end of 1983?

With all the talk in the air, I think a lot of people would assume that we spent less. The truth of the matter is that we spent from $36 billion to $56 billion in round numbers; a $20 billion increase. So it isn't that programs are being cut. That is a pretty significant increase under anyone's definition. It is a question of whether we will continue to let it grow that fast, as Senator Durenberger indicated. Having said that, we are going to listen to the Deputy Secretary. And thank you again for coming. You may proceed.

STATEMENT OF ROBERT B. HELMS, DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION/HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. HELMS. First of all, I would like to thank you for the opportunity to return to the beautiful State of New Mexico and also commend both of you for the interest that you have taken. I am in

firm agreement with the opening remarks that all of us in Washington need to get out into the States and local areas and find out what is really going on. I commend you on holding this hearing. My purpose today is to kind of set the stage for talking about what is going on in the national marketplace.

I intend to give some examples about how the private sector is responding to the health care program. This information has in large part been collected as a result of a series of studies on private sector initiatives being conducted in the office of the Assistant Secretary for Planning and Evaluation of HHS.

NEW APPROACH TO HEALTH POLICY

When the Reagan administration came in, in 1981, we said we wanted to take a new approach to health policy. We wanted to reject the regulatory approaches that were so common and politically popular and we wanted to emphasize health policies that were designed to change basic incentives of all the basic players in the system. This was based on a view that the health cost problem had been caused by a number of perverse incentives over the last few years, factors such as new medical knowledge, growth and income expansion of medical health programs and tax problems that work in tandem to increase the cost of health care. During the post-war period there was a large increase in commercial insurance and Government programs, two forces that increased the proportion of medical payments financed by a variety of third-party payers. And this created the third-party payment program which had rather weak incentives to contain costs.

However, the market is changing. And I think this hearing will certainly show that. During the Reagan administration the general rate of inflation has declined dramatically from 13.5 percent in 1980 to 3.2 percent in 1983. Since general inflation has been identified as accounting for over 50 percent of the increase in health expenditures over the last decade, this decline in the general rate of inflation is having a predictable beneficial effect on the rate of increase in health expenditures. Total health expenditures which were increasing at a rate of 15.8 percent in 1980 have now declined to 10.1 percent in 1983. The rate of growth of health care prices has declined from 10.9 percent in 1980 to 8.7 percent in 1982.

While this looks somewhat encouraging, compared to the situation we were in just 4 years ago, we still obviously have a cost problem. Not only do medical care costs remain above the general rate of inflation, the sheer size of the health cost problem is still a threat to the health care budgets of all levels of government and every company and individual that has to buy their own health insurance.

STEP BACKWARD

This continuing problem with health costs has kept alive the strong propensity to, for example, regulate in State legislatures and the U.S. Congress. In my view, this movement back to regulatory solutions, such as we see in the Kennedy-Gephardt bill, would be a mistake. As both of you said in your opening remarks, the pri-

vate market can control health care costs in a more efficient and equitable manner than can Government regulators.

The Reagan administration wants to keep the emphasis on incentives, providing an environment conducive to the orderly working of private market forces. There is ample evidence to suggest that cost containment can be achieved through incentive strategies.

FORCES AFFECTING PRIVATE SECTOR INITIATIVES

The next section goes into just some basic forces which I think have changed the attitudes of the private sector. Basically, these are that people are reacting to the high rates of increase and realize that they cannot continue to afford it. In addition, Congress, by defeating the Carter administration Hospital Cost Containment Act, and then passing the upper limits in 1981, and then prospective payments in 1983, gave some strong signals to everyone in the private sector that it was time for them to take care of the problem themselves.

So the diversity of private sector strategies, I think, are to be applauded. The private sector is assuming a critical role in fostering market incentives that foster cost containment and efficiency in the health care system.

EXAMPLES OF PRIVATE SECTOR REFORMS

Now, the following presents some examples of things that are happening in various parts of the private sector. First, benefits redesign on the part of private sector employers. Some of this is going on through health care coalitions with business firms taking an active interest in trying to control their own costs. Private health insurance financed primarily by employers accounts for 30 percent of the Nation's health care expenditures and can be a potent market influence. Restructuring of health benefits is thus one major area of private sector cost management activity.

HIGHER COST-SHARING AND RESTRUCTURING OF BENEFITS

Examples of recent surveys which indicate a shift toward higher cost-sharing plans and restructuring of benefits are: The William Mercer, Inc., survey which found that 50 percent of the firms of 25,000 employees or more have either increased deductibles or established higher copayments for services. The Hay Associates survey indicated that one-third of the firms responding to their survey had either recently increased their deductible or were considering an increase. Similarly, 25 percent of the firms had either recently increased the coinsurance or were considering an increase. This can be significant for individual firms.

For example, United States Steel dramatically reduced its hospital rate for 18,000 salaried employees by adding a $304 deductible on hospital care. Since 1982, when the deductible was introduced, hospital admissions have declined by 20 percent. Similarly, a $50 deductible on outpatient emergency visits reduced those visits by one-third.

There is a complementary emphasis on benefit enhancements that promote more cost-effective delivery of services. For example,

the Hay Associates survey found that 13 percent of the respondent firms require a second surgical opinion; 53 percent cover preadmission testing and 73 percent provide coverage for ambulatory surgery. Also, 50 percent of the firms eliminated the reimbursement differential for inpatient care. Benefit enhancements that shift the focus of care or reduce the hospital rates are relatively easy to implement. Given early estimates of savings, their popularity is likely to increase, especially in conjunction with plan design changes that increase cost sharing.

The next paragraph talks a little bit about cafeteria plans and the movement in firms to combine this with a choice for different kinds of benefits. This is a popular type of thing which is growing. Most of the benefit design changes is an attempt to control, by increasing employee cost sharing, and providing incentive to provide appropriate levels of cost of services. The intent is that benefit design changes focus consumer attention on health care cost issues and the ways to use the health care system more efficiently. Utilization patterns can be expected to shift from inpatient to outpatient.

HEALTH MAINTENANCE ORGANIZATIONS

Since the 1970's, the Federal Government has also promoted multiple choice through the dual-choice provisions of the Health Maintenance Organization Act. A 1982 survey of major employers showed that 53 percent offered employees generally a choice between a standard insurance plan and a prepaid HMO plan, in contrast to only 30 percent of the firms in 1978. HMO enrollments have increased by over 130 percent since 1974. Also, firms have taken a more active role in promoting alternative delivery systems. Ford Motor, R. J. Reynolds, and John Deere, for example, have been instrumental in establishing HMO's for their employees.

PREFERRED PROVIDER ORGANIZATIONS

Now, a word about preferred provider organizations. This you mentioned earlier as an example of the experimentation that is involving a lot of sectors of the health care delivery system. The PPO concept combines the attractive feature of a fee for service system and an HMO limited panel of providers. Generally, the PPO is offered in conjunction with the traditional health insurance with some financial incentives for people to select from the list of preferred providers. Now, a great deal of interest is being expressed by insurance companies, physicians, hospitals, and so on.

There is a lot of talk about this activity, as Senator Durenberger has indicated, in California, but it is not just a California phenomenon. The PPO concept is taking hold in Richmond, Va.; Cleveland, Ohio; Salt Lake City, Utah; Denver, Colo.; Minneapolis, Minn., just to name a few of the active areas.

And the preliminary evidence indicates that that is attractive to employees. For example, over 20 percent of Ameritrust employees in Cleveland selected one of the three PPO options during the initial open season. The $42 monthly premium paid by Ameritrust employees for PPO coverage was $46 less than coverage available under the Blue Cross/Prudential plan. The Deseret Mutual PPO,

Salt Lake City, attracted 85 percent of the eligible employees. Since 1981, referral and specialists costs have been reduced 10 percent and premiums only increased 1.2 percent per year.

Utilization review is also getting a lot more attention from private sector employees. The 1983 Hay Associates survey indicates that 39 percent of respondent firms review claims to determine trends and problem areas. Implementation of claims in utilization review programs, such as those developed by AT&T and John Deere, serve as an intelligence system to identify cost-problem areas, develop targeted cost containment strategies, and in the instance of PPO's, select cost-efficient providers.

CHANGES IN THE HOSPITAL INDUSTRY

There is a good deal of interest in health promotion, but let me say a few things about changes in the hospital industry itself, since I think it is of particular importance to this hearing. The medicare prospective system has only been in effect since October 1. However, it is already having a positive effect on the hospital industry. Most hospitals, large and small, are taking a serious and business-like look at their case-mix profile, analyzing practice patterns and costs by DRG and implementing patient management protocols.

Hospitals are actively engaging in strategic planning, undergoing internal assessment and evaluating their mission, and their relationship to the other delivery systems in the community. The DRG system has created an impetus for applying sophisticated business and management practices. And to quote Jack Owen for the AHA, the magic of the prospective system is "inducing new incentives to manage hospitals differently." Over the next decade the hospital industry can be expected to be involved in a more complex and diversified network. A lot more specialization, horizontal diversification, and vertical integration into other kinds of things.

THE CONSUMER AND THE HIGH COST OF HOSPITAL CARE

Let me say a word about consumers. A recent survey by the Equitable Life Insurance Society bears witness to the widespread support for fundamental changes in the U.S. health care system. Survey respondents included a cross section of the general public; business executives, hospital administrators, physicians, and union leaders. Overall, the respondents demonstrated sophisticated understanding of the health care cost problem recognizing that programs and practices that benefit them are also a source of inflation in health care spending. The lack of price competition was identified as a major reason for the rise in health care spending.

Also, there appears to be a willingness to accept a broad range of cost-containment strategies on the part of the public. So, contrary to conventional wisdom, this survey indicates that the American public would support cost-containment programs that increase out-of-pocket costs and introduce limits on freedom of choice in selecting providers.

We also have good evidence from the experiments that consumers are willing and able to respond to private sector initiatives. Just as in any other market, the consumer can be expected to control their own costs, if given the incentive to do so.

In conclusion, these examples should begin to illustrate what we know about how the key players in health are attempting to control health costs. These changes have come about in response to over 20 years of increasing health costs and the recent realization that the Federal Government did not have any magic solution to this problem.

HEALTH TAX SUBSIDY HINDERS REFORMS

However, there is still one force that is holding back the private sector in its efforts to control costs. This impediment is the continuing and excessive tax subsidy for the purchase of health insurance. This subsidy distorts purchasing decisions which enhance the value of health insurance at the expense of wages.

To correct this perverse incentive, the administration has proposed to limit the amount of health insurance that can be counted as tax-free income. This is not a tax on health benefits, as the Kennedy-Gephardt material likes to describe it. The proposed limit would be $175 per month for a family policy, and $70 for a single policy. The major effect of this limit would be to promote these private sector activities which we are talking about today. I think it will give an even stronger incentive for people to go out there and try to control the health care problem.

In conclusion, I would like to leave one reminder to all those that are considering how to control health costs. I would ask that everyone remember the very personal nature of medical care. Medical care delivery involves a personal relationship between an individual provider and a patient. The "value" of the services delivered is often measured in very subjective terms. On the part of the patient, a lot of times it is just information which is very useful to the patient.

My point is that any attempts by an outside party to control costs by arbitrary rules will be difficult to enforce and likely to be perceived by the patient and the provider as inconsistent with quality care. That is why it is imperative that we think in terms of changing consumer and provider incentive rather than in controlling costs through regulation. We can assure quality and control costs only if we create the right incentives to do so. I will be glad to try to answer any questions.

Chairman DOMENICI. Senator Durenberger.

PHILOSOPHY OF PRIVATE BETTER THAN GOVERNMENT

Senator DURENBERGER. Thank you very much, Mr. Helms. There are probably a variety of questions I could ask you, but I think what we are all trying to do is figure out whether we are on the cutting edge of something new. And your testimony is a good review of where things are, and some of the new things that are coming on line. But I think that one of the things that probably bothers a lot of people is, there seems to be in this administration a philosophy that the private sector can do everything better than the Government. We either ought to abolish the Government or back it out to the point where the whole private sector just takes on things, and you see that in budgetary waste, for example. I

know Pete sees a lot of it in the public works. I see it cutting way back on research and development.

The dean just told us a little while ago that there is almost nothing by way of increased funding for the National Institutes of Health. Somehow there is a notion that the private sector is so terrific out there that we ought to just let them go to work and somehow or other they will take care of our problems. And it is obvious that those that believe in competition and choice have to rely on the private sector to work, as Pete pointed out, and Rebecca has pointed out in her statement on behalf of Jeff awhile ago; you have the problems when the private sector goes to work on what it does best.

It doesn't necessarily do the poorer American the best. It doesn't necessarily do academic education. It doesn't necessarily do research. I mean who is doing research at Kennecott Copper these days when the copper industry is flat on its back? I mean who is doing geological research in this country if it isn't done in institutions? My question is: What is the balance in this administration, as you see it, in the health policy, between the Government role and a private sector role?

REGULATION A MAGIC FIX

Mr. HELMS. I think it is an oversimplification in saying the Reagan administration is stepping back and saying the private sector can do everything about every problem. But compared to the mentality that existed in Washington and a lot of the country for a long time about health policy matters and so on, I think it is healthy to put a little more emphasis on what the private sector can do as opposed to so much emphasis that somehow regulation is a magic solution.

I have written some things back, when I was an academic economist, about the history of regulation, about those railroads and so on, that you were talking about. I was very glad to hear you bring up that example. I think there is a kind of political attractiveness to regulations, a kind of quick fix for some perceived problem. And the problem is that people never go back to weigh the balance between what the Government can do best and what the private sector can do best.

I think the change in emphasis is a healthy one. We have, as you know, a difficult budget situation, but Secretary Kiker and Secretary Heckler have fought some very tough battles within the administration to try to maintain the funding for the National Institutes of Health, to try to get at the basic research which we think is a very legitimate function of the National Government.

IMPLEMENTATION OF PROSPECTIVE PAYMENT

Senator DURENBERGER. Let me take you to the implementation of prospective payment and also to what I said earlier, which a lot of folks may not believe, but it is realistic; that is, we will move quickly beyond hospitals to include doctors and nurses and skilled nursing facilities and home health and so on. But we haven't even got the hospitals going, every hospital in the country. It was deliberately a 3-year phase. We see certain problems.

We knew we would have early discharges, but one thing we haven't got is regulations from this administration on how to do peer reviews. We put in place a peer review process. I read through your paper and I read utilization review to be John Deere, and United States Steel and folks like that to be insurors, and that is sort of what I see sometimes from the administration: "Well, they are doing a great job, these folks."

Do we really need to have the physician involvement? And yet if this whole system is going to work, your last paragraph is the most important. We are in the people business, not just in the competition business, and we have to assure people of that element of quality of care, and we have to assure physicians they are not going to be compromised in the process. Maybe you can just alert us all to where the whole peer review process is at right now so we can expect to see some guidance to the physician groups and other groups in New Mexico, and other States, so that they can help us guide this process.

Mr. HELMS. As I think you are well aware, there is an attempt to finalize the regulations in the department. I don't have the latest information from the Health Care Financing Administration on exactly where those are, but I think we have indicated a willingness to try to get these regulations finalized and out. But I think the Administration's position went back, as you well know, to a certain disenchantment with the old TSRO system.

Senator DURENBERGER. Mine, too.

Mr. HELMS. There is a better way to do it. And we are hoping that our policies now and the ones that the Congress has passed will try to put the emphasis back on some local incentives to do that.

OCTOBER 1 TIME OF IMPLEMENTATION OF PLAN

Senator DURENBERGER. But you can't assure any of these people out here, who are going to be commenting on this change in medicare, that there is going to be a process in place that quickly? We have an October 1 deadline in which all of these across the country, all 50 of them, are supposed to be going. There is no guidance from the administration yet on how to do them.

Mr. HELMS. Let me say the administration is very aware of that and trying to get them out, but I cannot tell you exactly when that will happen.

Senator DURENBERGER. OK.

EXPLAIN CHANGES IN SIMPLER TERMS

Chairman DOMENICI. I just have a couple, Doctor. I was telling Senator Durenberger, as I heard your testimony, that probably for the experts and well-informed in the audience that they understood, and since we work on it all the time we understood, but, frankly, I think since we have to make some fundamental change, and you are really saying that, I think you ought to get some people to help you make a presentation so that these people up here that have to tell the public about it will get a feel for it.

Let me tell you what has happened to me. I have to explain inflation and I used to do it your way. "It was this and now it's this."

And people don't understand that. What I do now is tell them what a loaf of bread would have cost if we hadn't brought inflation down. And I think I can now prove it would be 70 cents a loaf higher if we had inflation as we had it 4 years ago, compared to what a loaf of bread is today.

When we speak of employers spending too much for health insurance and deducting it, I think we have to find a better way to explain to the people what that means. And I would urge that you, because you obviously understand not only medical delivery but economics very well, I would urge that you work on that, because I am not so sure that the public understand what we are talking about.

Having said that, let me ask you this. As you review the success and movement in these changes, do you have some orderly way of trying to find out what problems it is causing, also?

Mr. HELMS. Yes. We are, in the Health Care Financing Administration and the Department, putting a great deal of effort into monitoring the implementation of the prospective payment system. As you know, Congress in the legislation required the Department to provide not only periodical reports but a number of required studies about how to implement these different kinds of new prospective payments, and so on, and there is a great deal of activity in the Department on those. I am personally involved in the one on how to include capital.

Most of the others are being done within the Health Care Financing Administration, but there has been an extensive review of the data processes, collecting the data of the implementation, what is happening to admissions. We have identified this by each kind of alleged perverse incentive that exists, the gaming problems in prospective payment, and we are in the process of trying to get very good data. We are even in some negotiations. We are trying to come up with a model somewhat analogous to models that are used to project early election returns in the sense that when we get partial data to what extent can we extend this and get early warnings about what kinds of problems there are.

PLAN POSES PROBLEM FOR INDIGENTS AND MEDICAL SCHOOLS

Chairman DOMENICI. Let me suggest that already, without a lot of information, we have been told today, and I assume David has been told on this whole trip, that there are parts of the health delivery system that we have got to be worried about as we move toward competition, and that is the indigent care and what happens to those institutions that were doing it. Surely the competition up the street doesn't compete for that. And I am not even sure the voucher kind of approach will help that. But, anyhow, that is one.

The other is the medical school as a deliverer of health care and provider of professional doctors, as I hope is still the primary goal. I think it is clear they are going to have some trouble in this transition. I guess it is that kind of thing that I am asking about. What are we doing to make sure that we understand that and that you all understand that, and that suggestions coming from those that

are constructive in the area are given every serious consideration? Can you just talk about that a little bit?

Mr. HELMS. Yes. I will be glad to try. In the graduate medical education, we have a rather large study going on about that to try to separate out the costs and so on and we will be using that data base, and that information and so on as a basis for a study on the effects of the prospective payments on the teaching hospital sector, and we are trying to monitor all of the admission kind of practices and the effect on all kinds of hospitals including the public hospitals which have a large proportion of indigent care.

I, too, am aware that that is a considerable problem. I have heard about it already this morning here. But the Department is aware of those and is trying its best to study and see what kind of alternatives there are. I think you realize, though, that you are talking about some expensive kinds of propositions to really go in and try to take care of all of these, in essence, new populations which are not now eligible for medicare in some cases. So it is a broader problem than medicare, but one which we are going to try to watch as carefully as we can.

APPLY A SENSITIVITY QUOTIENT TOWARD POOR

Chairman DOMENICI. I guess what I am saying, and maybe this is just part of being an elected official, but it seems to me that success and reform is frequently directly related to the perception on the part of the public as to how those most in need get helped or hurt by the reform. And it isn't necessary that that be a big piece. The reform might fail if it is just a tiny piece. But Americans generally are sensitive. And if they don't think that we have that solved, even if it is 1 percent, then they may say, "Let's don't do any of this reform."

That is an exaggeration, but that is how I see it working for the people of this State. And from time to time I am merely suggesting that you all apply sort of a sensitivity quotient like that to it, because I think it makes your job easier to seek the truth.

Senator DURENBERGER. Pete, in 1982 you and I probably spent more time than all the Congress spent on the President's new proposition. Inherent in there, particularly on the public assistance part, we are talking medicaid, AFDC, and food stamps, if we can do a better job, all of us, somehow, in helping the indigent or the poor or those without access to health care without just adding money. We know there are better ways to do these things and that is part of what we wrestled with for the better part of a year. How do you first decide what the national responsibility is, and how are you going to effect it at other levels?

Chairman DOMENICI. But you could get that whole thing thrown topsy-turvy, where you are describing an $80 to $100 billion switch in responsibility and you could get it thrown topsy-turvy by half a billion. If there is a half a billion in responsibility that you can't account for in that shuffle, then you lose the whole package. You get the papers saying and Governors and others saying, "We are not doing it." And the ratio was 3 or 4 percent that you didn't solve. I guess that is the only point I want to make. Thank you for that observation. Thank you very much, Doctor.

The next panel is Marion Jordan, M.D., president-elect, New Mexico Medical Society, and Dallas Rychener, president of the New Mexico Association of Home Health Agencies.

Doctor, it is nice to have you. Dr. Jordan, would you proceed first?

STATEMENT OF W. MARION JORDAN, M.D., PRESIDENT-ELECT, NEW MEXICO MEDICAL SOCIETY

Dr. JORDAN. Thank you, Senator Domenici and Senator Durenberger. It is my pleasure to represent the New Mexico Medical Association during this hearing on medicare reform. It is our fondest wish that the medical system can be evaluated fully and some substantial effort made to preserve it in the best possible manner to help the people it was intended to help and provide flexibility to maximize its strength.

PROSPECTIVE PRICING TEMPORARY FIX

For too many years repair to the system has been made piecemeal and perhaps too many Band-Aids have been applied. What really may be needed is a new look at the whole mechanism of providing the revenues for the medicare system and making payments to providers of service. One might say that the new system of prospective pricing based on diagnostic related groups is a temporary holding measure until a more indepth evaluation can be made.

The new system of prospective pricing based on DRG's has only just begun and only a few hospitals in New Mexico have actually started to use this mechanism. At this time, we do not have much information on what impact the new system will have on patient care, physician practices, hospital-physician relations, and other matters. We do have our concerns.

As president-elect of the New Mexico Medical Society, I am making a concerted effort to understand the diagnostic related groups. I have served on the Medical Records Committee of a large hospital system in Albuquerque, 6 years as its chairman, and we are wrestling with DRG's and many modifiers. We have spent a lot of time trying to help the members of our medical staff understand the new system and its implications. I can assure you that this is no easy task. I am sure that the same problem exists in most of the hospitals in New Mexico.

KEEP CARE IN MIND AND NOT JUST COST

The members of the New Mexico Medical Society are chiefly concerned about how the quality of care for our patients will be affected by the new pricing system for hospital care. We will be ever on guard that quality of care does not suffer when the method for caring for our patients is concerned. We hope and pray that the review mechanism that will be used to monitor hospital and physician behavior during this phase of medicare reform will keep, certainly, the quality of care in mind and not just the cost. The New Mexico Medical Society is urging all its members to practice in a cost-effective manner, while they strive to do the best for their patients. We think it is of the utmost importance to have a review organization, composed mostly of physicians, to provide review for

medicare and other Government financed programs so that we can assure quality.

PLAN COULD CAUSE STRESS ON HOSPITALS

As hospitals cope with the new prospective pricing system for medicare and strive to maintain revenues to provide essential services, we are concerned that there will be much stress between hospitals and their medical staffs. In order to continue making ends meet, some hospitals may discontinue some very costly but needed services. If this impacts on what kind of care we can give our patients, all of us in the healthcare field, as well as the Government and the public at large, should be concerned.

The issue of physician access to hospital facilities will probably intensify for the New Mexico Medical Society and other similar organizations. Some hospitals may begin to alter the composition of their medical staff as a mechanism to implement their "product mix" strategies. For example, to deemphasize an "unprofitable" service, some hospitals may attempt to reduce the number of physicians on staff who specialize in that service.

IMPACT ON PHYSICIANS' ETHICAL STANDARDS

We are also concerned that some physician staff privileges will be in jeopardy if they do not conform to some standard other than the quality of care that they give. The stress on the physician under these circumstances may encroach on their ethical standards. The fairness of this approach and its impact on the ability of the medical staff to serve the needs of the community are likely to be questioned by physicians.

Further, if economic pressure on hospitals increases, and further changes occur, an increasing proportion of physicians may not be able to obtain hospital privileges.

EFFECT OF PLAN ON ONE-HOSPITAL AREAS

In New Mexico, we are very concerned about what effect the prospective pricing system based on DRG's will have on our hospitals in the less-populated areas of the State. In communities where there is only one hospital, it would be disastrous for that facility to be forced to close. As I travel around the State talking to the men and women of the New Mexico Medical Society, I find that there are already problems with the healthcare facilities in some of these communities. I am not sure how much more stress these communities can take. As the new prospective pricing system is put into place gradually, we will monitor the effect, especially on those facilities in the less populated areas of our State.

ASSIGNMENT OF BENEFITS TO PHYSICIANS

Another issue that continues to surface and becomes more intense is that of "assignment of benefits." This may mean different things to different people, but as it regards medicare, it means that the physician—or in some cases, nonphysician practitioners—must accept what medicare or third-party intermediaries determine will be paid for services provided. There are times when assignment of

benefits helps all concerned. Recently, however, there has been more pressure on physicians to accept assignment and not bill the patient for the difference between what medicare pays and the actual charges.

In the fall of 1983, an attempt was made in the Congress of the United States to mandate assignment for physician services to hospital inpatients. Moreover, an additional provision would have forced hospitals to consider whether or not a physician took assignment when granting or renewing staff privileges. Neither of these in the best interest of the people who are intended to benefit from medicare.

Whether a physician will accept assignment for services rendered to patients entitled to medicaid benefits should be left up to the patient and that patient's doctor. It is the position of the New Mexico Medical Society that the contract for services is between the patient and physician, therefore efforts to allow greater flexibility, as you mentioned earlier, in that relationship should be made. The patient and the physician, during discussion of the patient's care and the cost of it, should be encouraged to discuss methods of payments, which may include medicare, additional health insurance, and the patient's own resources. The current system should be maintained where there is an option regarding assignment of benefits.

I would like to remind the committee that medicare and/or the final intermediary use many complicated formulas to arrive at what is the "allowable" charge. Many times this is not fully explained to the patient and correspondence to the patient explaining what the medicare allowable is, often is so worded that it causes confusion and, many times, stress between the patient and the physician.

REEXAMINATION OF HEALTH FINANCING SYSTEM

Now, perhaps, what we really need is a major reexamination of the medicare health financing system Then major significant but fair reforms could make it possible to keep some faith with the American people on promises made.

In the background information to regulations called interim final rule on prospective payment system and DRG's, the Health Care Financing Administration states:

> The Social Security Amendments of 1965 established Title XVIII of the Social Security Act which authorized the establishment of the medicare program to pay part of the costs of health care services furnished to eligible beneficiaries. Part A of the program (hospital insurance) provides basic health insurance protection against costs of inpatient hospital care and other inpatient or home health care. Part B of the program (supplementary medical insurance) provides volunteer supplementary insurance covering most physician services and certain other items and services not covered under Part A.

I have included this statement to make some points about the intention of the medicare program and its perception. Note that the Health Care Financing Administration uses the term, "to pay part of the costs." This is a very important concept and should not be overlooked. The problem we are running into is that, as time goes on, those who are in a position to decide determine that medicare will pay a lesser part and someone else has to pay the rest. That is

no doubt the way it should be, but this point needs to be emphasized more to the patient.

The comments go on to stress the concept of voluntary supplementary insurance covering most physician services. Many times the patient and physician are confused about what medicare will pay in a particular instance. One cannot easily comprehend how medicare and the final intermediary arrive at the allowable payment or reimbursement. In a reform, these could be simplified so that when services are rendered, the patient can know what medicare will pay and what other insurance will pay. At least both patient and doctor will then know what needs to be paid from personal funds, providing the funds are adequate.

Adequate financing of the medicare trust fund and insurance programs must be seriously addressed. It has been stated that the medicare annual deficit will amount to more than $138 billion by the year 2005—and I must confess since I wrote this, I found $250 billion by 1990—so we are really in a stressful situation, even with the DRG system in place, unless there are significant increases in projected revenues.

WAGES GREAT COST FOR HOSPITALS

We must not look for financing alternatives including diagnostic related groupings to provide the remedy for medicare cost problems. Perhaps the cost cutting potential of DRG's is much less than most people have been led to believe. It must be pointed out, and I have stressed this many times, that the largest cost to hospitals are employee wages. These alone account for up to 60 percent or more of a hospital's fixed overhead costs. I am not sure I can provide any answers regarding more financing, but we must be honest and say that we most find some or admit that the medicare program is in grave jeopardy, which we already have.

DELAY TIME OF ELIGIBILITY FOR MEDICARE

Other reforms that could be strong medicine would include delaying the time when a person is eligible for medicare benefits. This could be done gradually and be less painful, as perhaps suggested in the social security amendments recently. We must encourage our retired people to keep their health insurance intact, especially when they can afford it. Serious consideration should be given to making medicare the secondary or supplementary insurance when possible, rather than the other way around.

A step in the right direction was when provision was made for medicare to become the secondary insurance for those who continue to work and the employer provides a good health insurance plan, as many do—such as my dad's. There are many situations where patients who are eligible for medicare benefits also have good health insurance either because it is provided by an employer or they have been wise enough to continue health insurance in force.

MEDICARE MEANS TEST NEEDS LOOKING AT

Those people who retire and are eligible for medicare benefits should be advised to keep some health insurance in force. Those involved in providing care and financing should take the responsibility seriously and develop a program which would be worthwile.

Although at this time it may be an anathema to many, and potentially hard to sell, some sort of means test may deserve at least a closer look.

I can assure you that the New Mexico Medical Society and other State and national medical organizations stand ready to help you and the administration make progress in solving the problem of financing health care for the elderly, retired, and disabled citizens.

We are going to be ever cognizant of cost effective medical care. We are addressing it at all levels of our federation. We know that we are in a new era and we think that we will be able to rise to meet the challenge.

GOVERNMENT HINDERS ORGANIZED MEDICINE

There is one area in which the government has made it most difficult for us to have an impact and that is in the area of physicians' fees. If you want the help of organized medicine, and we think we can make an impact, we need more assurance that the Federal Trade Commission and the Justice Department will not sue us or that we will not be found in violation of antitrust laws if we attempt to field complaints from patients regarding physician fees. This is a ticklish subject but one which should be considered carefully. For a long time the prestige of the medical society has had a moderating influence. We honestly believe that the public wants us to be involved. We would like to respond.

Joseph Boyle, M.D., president-elect of the American Medical Association—then chairman of the AMA board of trustees—told the Senate Committee on Commerce:

> It concerns us that at a time when great emphasis is placed on health care costs, a Government agency is discouraging professions from reviewing exorbitant fees or disciplining those who charge them. The public is disadvantaged when such activities are abandoned.

The New Mexico Medical Society is most appreciative of this opportunity to be invited and allowed to make these remarks. Please don't hesitate to call on us at any time. We look forward to making a significant contribution to solving these many problems.

Chairman DOMENICI. Thank you very much, Doctor.

Mr. Rychener.

STATEMENT OF DALLAS L. RYCHENER, PRESIDENT, NEW MEXICO ASSOCIATION OF HOME HEALTH AGENCIES

EFFECT OF PROPOSED SYSTEM ON HOME HEALTH CARE

Mr. RYCHENER. Thank you. I am here this morning as president of the New Mexico Association of Home Health Agencies to comment on the effect of the hospital prospective payment system on the home health industry. The New Mexico Association of Home Health Agencies represents about 30 member agencies throughout

the State of New Mexico. Member agencies of the association include hospital-based, nursing home-based, Visiting Nurses Associations, proprietary and various types of nonprofit programs. The majority of home health agencies in New Mexico are small, rural programs; many of them are the sole providers of home health care in their community.

NEW SYSTEM WILL HAVE SIDE EFFECTS

The medicare prospective payment system for hospitals is a dramatic change in reimbursement policy. While there is much disagreement about the operational details of the system, the concept itself has widespread support. The full impact of the prospective payment system will not be known for some time. It seems safe to say, however, that any change in the health care system, as significant as this one, will have a ripple effect far beyond the walls of the hospital.

It is impossible to make major adjustments in one sector of the health care system without affecting other areas. It is like an inflated balloon. If you constrict one area, you create a pressurized bulge somewhere else. Medicare must be dealt with on a system-wide basis. We must recognize and be prepared to deal with the side effects that result from remedial treatments to parts of the system.

The side effects of hospital prospective payment on home health care are not entirely clear at this time, but it is clear that the home health industry will not be left untouched. This will be a time of challenges and opportunities for home health care.

Some of those challenges and opportunities are expected to include:

First, an increased utilization of the post-hospitalization services, including home health care.

Second, referrals to home health of patients who require more intensive and extensive care.

Third, operational changes by home health agencies in order to provide the new skills and services that will be required.

Fourth, increased competition on the home health field, some appropriate, some inappropriate, which will cause agencies to seek more cost efficiency and to pursue new organizational structures in order to compete against the national chain organizations and the growth of hospital and nursing home programs.

HOSPITALS ENCOURAGED TO CONTROL STAYS

One of the most beneficial effects on home health agencies, and we believe to the patient, will be the increased importance and utilization of post-hospitalization services. The prospective payment system will provide strong incentives to the hospital to control the length of stay of their patients. When care can appropriately be provided outside the hospital facilities, alternative services are more likely to be used. Home health care providers have long advocated more effective hospital discharge planning on behalf of the patient to assure that the most appropriate care is provided in the most appropriate setting. Prospective payment provides an incentive for that to occur.

HIGHER LEVEL OF HOME CARE EXPECTED

In addition to an expected increase in home health referrals, we anticipate, due to earlier discharges, that the patients referred to home health will be in more acute stages of illness. These patients will require a higher level of care and more frequent visits than the average home health patient in the past. At the same time, medical tec-nology has progressed to the point where many procedures which previously could only be performed in the hospital can now be done safely and efficiently in the home setting.

Under prospective payment, hospitals will be encouraged, and in many instances forced, to rely on the home health care provider for these services. In New Mexico, we are already seeing a much higher level of hospital interest in the capability of home health agencies to provide total parenteral nutrition, chemotherapy, respiratory therapy and other high technology procedures in the home. We firmly believe that these referrals are totally appropriate from the standpoint of the patient's physical and psychosocial well-being as well as the potential cost savings to the health care system.

BARRIERS PLACED BY HCFA TO HOME CARE

The increased utilization, the addition of high technology services and procedures and even, in most cases, the increased competition are positive signs of a healthy industry. Unfortunately, there are also several debilitating symptoms which preclude us from making a completely optimistic prognosis. While hospitals are being encouraged to utilize alternative services and setting for the patient's care and rehabilitation, the Health Care Financing Administration [HCFA], through its fiscal intermediaries, has placed several hurdles and barriers between home health agencies and medicare reimbursement.

At a time when home health patients are expected to require a higher level of care, HCFA is attempting to curtail the frequency of reimbursable visits.

At a time when more patients with terminal illnesses are choosing to die at home, HCFA is denying payment for home health care to these patients because the intermediary has determined that "hospice care" is not a covered home benefit.

BARRIERS DUE TO MEMOS, DIRECTIVES, ET CETERA

These arbitrary actions are not taking place through the legislative process or even the regulatory process but rather through memos, directives and "guidelines." Even more arbitrarily, the medicare intermediaries' interpretation of these memos, directives and guidelines are flagrantly inconsistent from one State to another. A medicare beneficiary in New Mexico does not necessarily have a right to the same services as the medicare beneficiary in New York.

LAW EXPLICITLY DEFINES "INTERMITTENT CARE"

The use of "intermittent care" is especially relevant to our discussion of prospective payment. Senator Bingaman in his opening prepared statement has already expressed some of our concern in

this area. For a minute I was a little afraid that he was going to use my whole speech. But we do appreciate his comments and his support for home health care. As he mentioned in his prepared statement, when the home health benefit was passed in 1965, the statute authorized medicare reimbursement for "part-time or intermittent nursing care." Neither the statute nor the regulations provide any further definition or limitations on what constitutes intermittent care.

The intent seemed to be to differentiate between part-time home health care and full-time institutional care. However, HCFA, in its Home Health Agency Manual, states that while most patients require services no more frequently than several times a week, medicare will pay for part-time nursing care 7 days a week for a short period of time, 2 to 3 weeks, and longer under exceptional circumstances.

Over the years, and especially in the last 1 to 2 years, the definition of intermittent care has become increasingly restrictive. Again, the interpretations by the intermediaries vary significantly. Some intermediaries have determined that patients who require services 5 days per week do not qualify for the home health benefit because the care is not intermittent. Other intermediaries use the 2- to 3-week guideline as a maximum and will not reimburse for services beyond that, regardless of any unusual circumstances or the appropriateness of the care.

We have a similar concern with the current HCFA restrictions on payment for parenteral and enteral nutrition therapy services in the home. In a letter to HCFA Administrator, Dr. Carolyne Davis, dated January 24, 1984, Val Halamandaris, president of National Association for Home Care, states:

> There is nothing in the law, regulations, or guidelines which states that visits for I.V. therapies are not covered under the medicare home health benefit. These conditions, like others, are covered as skilled nursing care under the medicare home health benefit as long as the physician certifies the treatment as medically reasonable and necessary.
>
> The need for such skilled care will increase with the advent of the medicare hospital DRG system which already is discharging sicker patients more quickly to home health providers.

IMPLEMENTATION VARIES FROM STATE TO STATE

Yet, once again, through memos and directives HCFA has restricted payment. And, once again, the implementation varies from State to State. In some States, home health agencies receive payment for their visits but not for the supplies or equipment. Here in New Mexico, home health agencies have been told that new long-term enteral or parenteral therapy services or supplies are covered under the home health benefit.

The hospice care issue surfaced here recently in New Mexico. One of our member agencies was denied payment for services they had provided to a terminal patient. All conditions of coverage were met, including intermittent care, homebound and physician certification requirements. The reason for the denial was that the fiscal intermediary determined the level of care to be hospice care. Since hospice care is now reimbursable under medicare as a separate and distinct service, the intermediary seems to be saying that care of

the terminally ill is no longer a covered service under the home health benefit.

Because of the restrictive hospice regulations promulgated by HCFA, there are not going to be many medicare certified hospices in New Mexico, especially in the rural areas. The recent determination by the intermediary appears to eliminate the possibility of medicare reimbursable in-home health care being provided to terminal patients who either do not elect the hospice benefit or do not have access to a hospice program. We do not believe that was the intention of Congress when the hospice legislation was passed.

PROSPECTIVE PAYMENT PLAN CAN BE COSTLY TO SOME

Our concerns in these areas are directly related to the anticipated impact of prospective payment. If our projections prove reliable, home health agencies will be getting more and more of the very patients for whom HCFA is denying payment. No agency can exist for long under those conditions. Unless some recognition and remedial action is addressed to these issues, prospective payment will be a very costly experiment for those patients who find themselves somewhere in the cracks between the hospital, nursing home, and home health care.

Again, as Senator Bingaman indicated in his opening statement, we understand that Senators John Heinz and Lloyd Bentsen, as well as Senator Bingaman, will be introducing legislation entitled Home Health Care Protection Act of 1984 that would define intermittent care to include daily care for up to 60 days with physician certification and longer under unusual circumstances. We respectfully request your support for that bill when it is introduced. We would also like to take this opportunity to personally thank Senator Domenici for his efforts on behalf of home health care in New Mexico with respect to the intermittent care issue, hospice legislation and much more.

ALTERNATIVE PAYMENT SYSTEM

Before I close, I would like to comment briefly on the proposed application of an alternative payment system for the home health care. We are fully aware that prospective payment for hospitals will not in itself solve the problems facing the medicare problem and that other steps will certainly be necessary. We also recognize that there are some inherent problems in the current home health cost reimbursement system.

In December 1983, pursuant to Public Law 97-414, the Department of Health and Human Services awarded a grant for a 5-year demonstration project to test alternative reimbursement methodologies for home health agencies. Given the very limited home health data base currently in existence, we strongly urge Congress to wait for a full and final analysis of that project before enacting any alternative system for home health. We also urge that any consideration of an alternative reimbursement methodology take into account and address the actual effects of hospital prospective payment on home health care.

Thank you for this opportunity for the association to express its views. We stand ready to work with you or your staff to seek a solution to the issues that we have identified.

Chairman DOMENICI. Thank you very much.

[The full prepared statement of Mr. Rychener follows:]

Testimony of
DALLAS L. RYCHENER, PRESIDENT
New Mexico Association of Home Health Agencies

before the
COMMITTEE ON THE BUDGET
United States Senate

at a hearing in
Albuquerque, New Mexico

February 15, 1984

My name is Dallas Rychener. I am Director of Planning and Development of Hospital Home Health Care, Inc., in Albuquerque, New Mexico. I am also President of the New Mexico Association of Home Health Agencies. It is in the latter capacity that I am here today to comment on the effect of the hospital prospective payment system on the home health industry.

The New Mexico Association of Home Health Agencies represents about 30 member agencies throughout the state of New Mexico. Member agencies of the Association include hospital-based, nursing home-based, Visiting Nurses Associations, proprietary and various types of non-profit programs. The majority of home health agencies in New Mexico are small, rural programs; many of them are the sole providers of home health care in their community.

We, too, are concerned about the high cost of health services in our country. Once considered to be a birthright of all citizens of the United States, health care is in danger of becoming a luxury affordable by the wealthy and rationed to the remainder of society through a system of priorities and governmental regulations.

We appreciate the efforts of the Senate Budget Committee and the Health Subcommittee of the Senate Finance Committee to address this fundamental issue and to save the Medicare program. We, in the home health industry, are committed to working with the members of Congress in seeking solutions that best preserve the adequacy of health care to Medicare dependents.

The Medicare prospective payment system for hospitals is a dramatic change in reimbursement policy. While there is much disagreement about the operational details of the system, the concept itself has widespread support. The full impact of the prospective payment system will not be known for some time. It seems safe to say, however, that any change in the health care system as significant as this one will have a ripple effect far beyond the walls of the hospital. It is impossible to make major adjustments in one sector of the health care system without affecting other areas. Like an inflated balloon, if you constrict one area you create a pressurized bulge somewhere else. Medicare must be dealt with on a system-wide basis. We must recognize and be prepared to deal with the side effects that result from remedial treatments to individual parts of the system.

The side effects of hospital prospective payment on home health care are not entirely clear at this time but it is clear that the home health industry will not be left untouched. This will be a time of challenges and opportunities for home health care.

1. One of the most beneficial effects on home health agencies, and we believe to the patient, will be the increased importance and utilization of post-hospitalization services. The prospective payment system will provide strong incentives to the hospital to control the length-of-stay of their

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patients. When care can appropriately be provided outside the hospital facilities, alternative services are more likely to be used. Home health care providers have long advocated more effective hospital discharge planning on behalf of the patient to assure that the most appropriate care is provided in the most appropriate setting. Prospective payment provides an incentive for that to occur.

2. In addition to an expected increase in home health referrals, we anticipate, due to earlier discharges, that the patients referred to home health will be in more acute stages of illness. These patients will require a higher level of care and more frequent visits than the average home health patient in the past. At the same time, medical technology has progressed to the point where many procedures which previously could only be performed in the hospital can now be done safely and efficiently in the home setting. Under prospective payment, hospitals will be encouraged and in many instances forced to rely on the home health care provider for these services. In New Mexico, we are already seeing a much higher level of hospital interest in the capability of home health agencies to provide total parenteral nutrition, chemotherapy, respiratory therapy and other high technology procedures in the home. We firmly believe that these referrals are totally appropriate from the standpoint of the patient's physical and psychosocial well-being as well as the potential cost savings to the health care system.

3. The higher level of care required by these patients will have a significant impact on the operations of many home health agencies. More of the agencies resources will have to be invested in obtaining the staff skills required either through recruitment or training of current staff. Staffing patterns of many agencies may need to change to allow more flexibility of service hours to meet the varied needs of the patients. Quality assurance procedures will have to be reviewed and revised to appropriately monitor the process and outcome of the new services and procedures. These changes will perhaps be most difficult in the rural agencies because of their more limited access to personnel, training programs and community support services. In the long run, the necessary changes, though momentarily troublesome, will facilitate the maturity of the industry as an essential component of the health care system.

4. As a result of prospective payment for hospitals, home health agencies will be forced to deal with two issues which in many ways are incompatible and which may result in significant structural changes in the home health industry. On one hand, home health agencies must develop closer working relationships with the hospitals so that the agency is attuned to the service needs of the discharged patient and the hospital is knowledgeable about the capabilities of the

agency. On the other hand, competition in the home health field is expected to increase dramatically with much of that competition coming from the hospitals themselves as they seek to diversify their services and retain the patient within their system.

Competition is not inherently good or bad. Its value must be judged on a situational basis. In a small rural, isolated community where a home health agency is adequately meeting the needs of the limited home health market and operating on a shoestring, the likely results of competition will be an increase in the cost per unit of service and the eventual demise of one or both of the programs. In at least two New Mexico communities, we have seen a national nursing home chain establish a competing home health program with no apparent preliminary market assessment and no justification other than to satisfy company policies. In cases as these, no one benefits from competition.

Freestanding home health agencies are especially concerned about the proliferation of hospital and nursing home based home health programs. Not only do these programs increase the competition, they also severely restrict the sources of referrals on which the freestanding agency has relied. The probable outcome will be the development of more official affiliations between hospitals and home health agencies, more multi-home health agency organizations and fewer independent voluntary agencies which were once the mainstream of the home health industry.

The increased utilization. the addition of new high technology services and procedures and even. in most cases, the increased competition are positive signs of a healthy industry. Unfortunately, there are also several debilitating symptoms which preclude us from making a completely optimistic prognosis. While hospitals are being encouraged to utilize alternative services and settings for the patients' care and rehabilitation. the Health Care Financing Administration (HCFA) through its fiscal intermediaries has placed several hurdles and barriers between home health agencies and Medicare reimbursement.

1. At a time that home health patients are expected to require a higher level of care, HCFA is attempting to curtail the frequency of reimburseable visits.

2. At a time when more patients are expected to be sent home for intravenous therapies, HCFA is redefining and restricting Medicare coverage of such services.

3. At a time when more patients with terminal illnesses are choosing to die at home. HCFA is denying payment for home health care to these patients because the intermediary has determined that "hospice care" is not a covered home health benefit.

These arbitrary actions are not taking place through the legislative process or even the regulatory process but rather through memos, directives and "guidelines." Even more arbitrarily, the Medicare intermediaries' interpretation of the memos, directives and guidelines are flagrantly inconsistent from one state to another. A Medicare beneficiary in New Mexico does not necessarily have a right to the same services as a Medicare beneficiary in New York.

The issue of "intermittent care" is especially relevant to our discussion of prospective payment. When the home health benefit was passed in 1965, the statute authorized Medicare reimbursement for "part-time or intermittent nursing care." Neither the statute nor the regulations provide any further definition or limitations on what constitutes intermittent care. The intent seemed to be to differentiate between part-time home health care and full-time institutional care. However, HCFA in its Home Health Agency Manual (HIM-11) states that while most patients require services no more frequently than several times a week, Medicare will pay for part-time nursing care seven days a week for a short period of time (2-3 weeks) and longer under exceptional circumstances. Over the years and especially in the last 1-2 years, the definition of intermittent care has become increasingly restrictive. Again, the interpretations by the intermediaries vary significantly. Some intermediaries have determined that patients who require services 5 days per week do not qualify for the home health benefit because the care is not intermittent. Other intermediaries use the 2-3 week guideline as a maximum and will not reimburse for services beyond that regardless of any unusual circumstances or the appropriateness of the care. (The New Mexico intermediary's Medicare Newsletter 83-45 dated October 15, 1983 regarding the intermittent care issue is appended to this testimony.)

We have a similar concern with the current HCFA restrictions on payment for parenteral and enteral nutritional therapy services in the home. In a letter to HCFA Administrator, Dr. Carolyne Davis, dated January 24, 1984, Val Halamandaris, President of the National Association for Home Care (NAHC), states,

> "There is nothing in the law, regulations, or guidelines which states that visits for I. V. therapies are not covered under the Medicare home health benefit. These conditions, like others, are covered as skilled nursing care under the Medicare home health benefit as long as the physician certifies the treatment as medically reasonable and necessary. The need for such skilled care will increase with the advent of the Medicare hospital DRG system which already is discharging sicker patients more quickly to home health providers." (The full body of the letter and accompanying NAHC report is attached as an addendum to this testimony.)

Yet, once again, through memos and directives, HCFA has restricted

payment. And once again the implementation varies from state to state. In some states, home health agencies receive payment for their visits but not for the supplies or equipment. Here in New Mexico, home health agencies have been told that no long term enteral or parenteral therapy services or supplies are covered under the home health benefit. (Medicare Newsletter 83-48 dated October 15, 1983 is appended to this testimony.)

The hospice care issue surfaced recently here in New Mexico. One of our member agencies was denied payment for services they had provided to a terminal patient. All conditions of coverage were met including intermittent care, homebound and physician certification requirements. The reason for the denial was that the fiscal intermediary determined the level of care to be hospice care. Since hospice care is now reimbursable under Medicare as a separate and distinct service, the intermediary seems to be saying that care of the terminally ill is no longer a covered service under the home health benefit.

Because of the restrictive hospice regulations promulgated by HCFA, there are not going to be many Medicare certified hospices in New Mexico especially in the rural areas. The recent determination by the intermediary appears to eliminate the possibility of Medicare reimbursable in-home care being provided to terminal patients who either do not elect the hospice benefit or do not have access to a hospice program. We do not believe that was the intention of Congress when the hospice legislation was passed.

Our concerns in these areas are directly related to the anticipated impact of prospective payment. If our projections prove reliable, home health agencies will be getting more and more of the very patients for whom HCFA is denying payment. No agency can exist for long under those conditions. Unless some recognition and remedial action is addressed to these issues, prospective payment will be a very costly experiment for those patients who find themselves somewhere in the cracks between the hospital, nursing home and home health care.

We understand that Senators John Heinz of Pennsylvania and Lloyd Bentsen of Texas plan to introduce legislation entitled "Home Care Protection Act of 1984" that would define intermittent care to include daily care for up to 60 days with physician certification and longer under unusual circumstances. We respectfully request your support for that bill when it is introduced. We would also like to take this opportunity to thank Senator Domenici for his efforts on behalf of home health care in respect to the intermittent care issue.

Before I close, I would like to comment briefly on the proposed application of an alternative payment system for home health care. We are fully aware that prospective payment for hospitals will not in itself solve the problems facing the Medicare program and that other steps will be necessary. We also recognize some of the inherent problems of the current home health cost-reimbursement system.

In December 1983, pursuant to P. L. 97-414, the Department of Health and Human Services awarded a grant for a five-year demonstration project to test alternative reimbursement methodologies for home health agencies. Given the very limited home health data base currently in existence, we strongly urge Congress to wait for a full and final analysis of that project before enacting any alternative system for home health. We also urge that any consideration of an alternative reimbursement methodology take into account and address the actual effects of hospital prospective payment on home health care.

Thank you for this opportunity to express our views. The New Mexico Association of Home Health Agencies stands ready to work with you or your staff to seek a solution to the issues we have identified.

Blue Cross
Blue Shield
of New Mexico

Federal Medicare
Intermediary

12800 Indian School Road, N.E.
Albuquerque, New Mexico 87112

Medicare

Claims & Benefit Information 505/292-2600
Customer Services 505/292-2600
General Administration 505/293-0240

MEDICARE NEWSLETTER 83-45

October 15, 1983

TO: All Medicare Certified Home Health Agencies

FROM: Medicare Division

SUBJECT: Intermittent Care Requirement for Home Health Services

Some questions have arisen recently regarding the intermittent care requirement for home health coverage of skilled nursing visits and aide visits. The sections of the Home Health Manual relating to intermittent care are 204.1 and 206.6. The purpose of this newsletter is to call your attention to those manual provisions that discuss the Medicare intermittent care regulations and clarify the existing policy.

Section 204.1 (HHA Manual) establish what are essentially minimum and maximum frequency parameters for the coverage of home health care, based on the patient's medical need. Generally, the intermittent requirement would not be met if the patient required skilled nursing visits less frequently than once every 60 days or if he/she required daily skilled nursing visits for more than 3 weeks. The minimum frequency requirement causes few, if any, problems; however, the daily visit limitation has generated a number of inquires in recent month. Daily visits are considered to be 5 or more visits by one discipline in a one week period.

The above referenced manual section permits the coverage of daily skilled care visits beyond 3 weeks in cases involving unusual circumstances. However, they also specify that as soon as the patient's physician makes the judgement (usually before the end of the 3 week period) that additional daily care will be required, the home health agency must forward medical documentation justifying the need for such additional services and include an estiamte of how much longer daily services will be required. (This requirement also applies to daily aide services.) The Intermediary must use its judgement as to what constitutes unusual circumstances and how long to pay for daily care beyond 3 weeks. However, these decisions will be made with the awareness that, since the inception of the Medicare program, daily skilled care and personal care services for indefinite or extended periods of time have never been considered to meet the statutory requirement of intermittent need.

When dealing with bills for daily care, we as an Intermediary must make one of several possible decisions depending on the facts of the individual case. For example:

1. It could determine that some or all of the daily visits from the beginning of care were not medically necessary, in which case waiver would be considered. Therefore, the question is now medical necessity rather than intermittent care.

2. It may determine that less frequent care is needed after the 2-3 weeks and limit the allowance to less than daily visits even if daily visits are billed. These denied services could be considered under waiver because the basis for denial would be a lack of medical necessity.

3. If there is no question about the medical necessity of the daily care, then it may be determined that:

   (A) The need for daily care continues beyond an initial 2-3 weeks but is likely to be reduced to less than daily care after a short additional time or
   (B) the beneficiary will likely be placed in a nursing home or some other setting within a short time, and we will continue to allow daily services for a limited time.

   These two situations would constitute unusual circumstances.

4. It may determine that the need for daily skilled care will continue for an indefinite period and, therefore, that Medicare will have to terminate all payments. Such a denial would be necessary because the intermittent care requirement is not met, and, thus, the denied services could not be considered under waiver.

It is important to keep in mind that denials relating to the intermittent care requirement are different from those relating to medical necessity. An intermittent care denial based on the fact that a patient needs a level of care that is either less intensive (fewer than one visit every 60 days) or more intensive (daily care for an extended time) than the Medicare home health benefit was intended to cover, is a technical denial not subject to payment under waiver of liability. A denial based on a determination that services were not reasonable and necessary or were custodial in nature is subject to consideration for payment under waiver of liability.

A THOUGHT PROCESS FOR HOME HEALTH COVERAGE

We believe that the following thought process, if applied by HHAs during their initial evaluations of patients and by the Intermediary during its review of home health bills, would significantly assist in determining whether or not the level and degree of care needed by a patient would be covered under Medicare's home health benefit.

1. First, it is necessary to determine whether the beneficiary meets the "homebound" requirement. If he/she is not homebound, nothing is payable under the home health benefit.

2. If the beneficiary meets the homebound requirement, the second area of consideration is the level and degree of need:

   (A) Does the patient need skilled nursing care of physical therapy or speech therapy?
   If the answer is no, nothing is payable under the home health benefit.

   (B) If the patient does need skilled nursing care of physical therapy or speech therapy, is that care needed on an intermittent basis, or on a daily basis for a short period of time (2-3 weeks)?
   If the answer is yes, the intermittent care requirement is met. If the need for daily care extends beyond three weeks, Medicare can continue to pay for the care only in unusual circumstances and only for a limited additional time, (1-2 weeks).

   (C) If the skilled and intermittent care requirements are met, does the patient also need personal care services?
   Medicare can pay for intermittent personal care services. Payment can also be made for daily personal care for a short period of time, usually no more than three weeks.

3. Finally, if (and only if) the homebound requirement is met and the need for a covered level and degree of skilled and personal care services has been established, the services themselves must be evaluated in terms of whether they are reasonable and necessary. This evaluation involves an assessment of not only the therapeutic value of the skilled services, but also the extent to which reasonable and necessary personal care is provided by the patient or other people in the home. It may be that only some (or perhaps none) of the personal care services are payable depending on how adequately the patient or others in the home fulfull the need.

This newsletter is a clarification of the existing Medicare policy on intermittent care. We will be adhering more closely to this policy beginning with dates of service November 1, 1983.

National Association for Home Care

REPORT

519 C Street, N.E. • Stanton Park, Washington, D.C. 20002 (202) 547-7424

REPORT #47 January 24, 1984

• • • SPECIAL REPORT • • •

NAHC ASSAULTS HCFA ATTEMPT TO RESTRICT PARENTERAL/ENTERAL NUTRITIONAL THERAPY SERVICES

In response to numerous complaints from home health agencies in North Carolina, Texas, New Mexico and Connecticut, NAHC President Val J. Halamandaris wrote HCFA January 26, 1984 challenging their policy of not allowing reimbursement for parenteral and enteral nutritional therapy visits under the Medicare Part A. NAHC also is challenging HCFA's interpretation that the supplies and equipment used in such therapies are considered reimbursable only under Part B as prosthetic devices.

As reported to NAHC, HHAs are being told in some states that one or more intravenous (IV) therapies are not covered under the Medicare Part A home health benefit. In one state, HHAs are being told no IV therapy (enteral, parenteral, antibiotic, chemo) is covered. Other states (particularly New Mexico, North Carolina, and Texas) are being told by FIs that no long term enteral or parenteral therapy services or supplies are covered under the Medicare home health benefit and that NG or levine tubes are considered prosthetic devices, billable only under Part B. Other FIs are being told visits will be paid for but not the supplies and equipment. And in other states, HHAs are being told by FIs that visits involving hyperalimentation work will not be covered because patients are taught about hyperalimentation in hospitals.

In his letter to HCFA Administrator Dr. Carolyne Davis, Mr. Halamandaris said that NAHC's position is that all IV therapy visits, supplies and equipment should be covered under the Medicare Part A home health benefits. The visits, including visits for hyperalimentation work, are skilled nursing care and should be allowable as long as they are medically reasonable and necessary as included in the plan of treatment.

In summary, NAHC's rationale is that there is nothing in the law, regulations, or guidelines which states that visits for IV therapies are not covered under the Medicare home health benefit. These conditions, like others, are covered as skilled nursing care under the Medicare home health benefit as long as the physician certifies the treatment as medically reasonable and necessary. The need for such skilled care will increase with the advent of the Medicare hospital DRG system which already is discharging sicker patients more quickly to home health providers.

As regards supplies and equipment for IV therapies, even if NG or levine tubes (or other supplies used in IV therapies) are considered prosthetic devices covered under Part B (which is a debatable issue) it in no way precludes coverage of the home health visit to treat the condition.

The net effect is to deny HHAs the ability to provide these services while permitting Part B suppliers, who are not licensed or supervised, to bill for these equipment/supplies (including a built-in labor cost) usually at higher rates than the HHA.

As regards hyperalimentation work, the law and regulations do not bar hyperalimentation or any other potential home care treatment on the presumption it should be done elsewhere. Furthermore, the Omnibus Reconciliation Act of 1980 removed the prior hospitalization requirement for home health coverage so there may be patients requiring hyperalimentation work who haven't been in the hospital. Even if a patient was discharged from the hospital and the hospital was supposed to do such training, it is irrelevant to an HHA doing it unless in the specific case it can be shown that the training was done in the hospital and done sufficiently recently to make home care hyperalimentation a duplicative service. Barring such a situation, the service should be allowable. To deny such claims would be contrary to the law, regulations and the reality of health care.

NAHC also pointed out that this new policy was being implemented based on a letter from HCFA, a "bulletin" in North Carolina, and a "newsletter" in Texas in violation of the rulemaking procedure required under the Administrative Procedure Act and small business impact assessment required under Executive Order 12291 and the Reduction in Paperwork Act of 1980.

NAHC members are urged to write NAHC's Research Division as soon as possible if they are experiencing similar problems with reimbursement for IV therapy visits, supplies or equipment.

The following is the full text of Val J. Halamandaris' January 24, 1984 letter to HCFA Administrator Dr. Carolyne Davis:

Dear Dr. Davis:

We are writing to object to recent directives by your agency and at least two fiscal intermediaries (Group Health Insurance, Inc. of Dallas, Texas and Blue Cross/Blue Shield of North Carolina) taking the position that parenteral/enteral therapy services, supplies and equipment are covered only as a prosthetic device (under Medicare Part B) and not as home health services under the Medicare Part A program. Enclosed herewith is a copy of the November 9, 1983 GHI Texas "newsletter", a draft of the December 9, 1983 BC/BS of North Carolina "bulletin", and a copy of the August 9, 1983 HCFA letter to the Blue Cross and Blue Shield Association — all of which reflect this new policy.

Our members in Texas, North Carolina, New Mexico and other states have advised us that intermediaries are telling them that certain intravenous (IV) therapies are not covered under the Mediare Part A home health benefit. In one state, the intermediary has advised home health agencies (HHAs) that the HCFA regional office has developed a new policy that no IV therapy (enteral, parenteral, antibiotic, chemo) will be covered under the Part A home health benefit. In other states HHAs are being told that no long term enteral or parenteral therapy services or supplies are covered under the Medicare home health benefit and that NG or levine tubes are considered prosthetic devices, billable only under Part B. Other HHAs are being told visits will be paid for but not the supplies and equipment. And in other states, HHAs are being told by FIs that visits involving hyperalimentation work will not be covered because patients are taught about hyperalimentation in hospitals.

Let me make our position clear from the outset. We believe the policies set forth in your August 9, 1983 memo and the directives of the Texas, North Carolina, New Mexico and other intermediaries ar legally unsound. The law and regulations indicate that all IV therapy visits, supplies and equipment should be covered under the Medicare Part A home health benefit. Medical services and supplies provided to patients at home by a home health agency are covered under the home health benefit so long as the conditions for coverage are met and the services are not expressly excluded by some other provision of law. The mere fact that certain medical services are covered under Medicare as prosthetic devices does not preclude their coverage as home health services.

There is nothing in the law, regulations, or guidelines which states that visits for IV therapies are not covered under the Medicare home health benefit. These conditions, like others, are covered as skilled nursing care under the Medicare home health benefit as long as the physician certifies the treatment as medically reasonable and necessary. The need for such skilled care will increase with the advent of the Medicare hospital DRG system which already is discharging sicker patients more quickly to home health providers.

As regards supplies and equipment for IV therapies, even if NG or levine tubes (or other supplies used in IV therapies) are considered prosthetic devices covered under Part B (which is a debatable issue) it in no way precludes coverage of the home health visit to treat the condition.

The net effect is to deny HHAs the ability to provide these services while permitting Part B suppliers, who are not licensed or supervised, to bill for these equipment/supplies (including a built-in labor cost) usually at higher rates than the HHA.

As regards hyperalimentation work, the law and regulations do not bar hyperalimentation or any other potential home care treatment on the presumption it should be done elsewhere. Furthermore, the Omnibus Reconciliation Act of 1980 removed the prior hospitalization requirement for home health coverage so there may be patients requiring hyperalimentation work who haven't been in the hospital. Even if a patient was discharged from the hospital and the hospital was supposed to do such training, it is irrelevant to an HHA doing it unless in the specific case it can be shown that the training was done in the hospital and done sufficiently recently to make home care hyperalimentation a duplicative service. Barring such a situation, the service should be allowable. To deny such claims would be contrary to the law, regulations and the reality of health care.

Furthermore, if your agency believes its position is correct then you must recognize (as you have in internal documents) that this is a new policy which affects the rights of many beneficiaries and home health care providers. As such, it cannot be validly implemented by "letters", "bulletins", and "newsletters" requires a regulaton promulgated under the rulemaking requirements of the Administrative Procedure Act (5 U.S.C 553). In addition, the new policy results in a shift of business away from HHAs to Part B suppliers and has a substantial negative impact on small businesses. As such, it cannot be validly implemented

without compliance with the small business impact requirement of Executive Order 12291 and the Reduction in Paperwork Act of 1980 (44 U.S.C. 3501, et. seq.).

It is our position that you and the intermediaries in question not only substantively are in error in your new policy, but procedurally already have violated the two laws and Executive Order cited above. Therefore, we are requesting that you (1) immediately advise all intermediaries that the August 9,1983 letter, other relevant HCFA directives and any policies based thereon are to be rescinded pending a review and (2) set up a meeting where your agency and our Association can discuss both procedural and substantive concerns before any further action is taken.

Let me now share with you a more detailed analysis which supports our position and the request outlined above.

I. Background

Parenteral and enteral nutritional therapy is required by patients who, due to illness or trauma, cannot ingest enough food orally to support normal activities of daily life. Parenteral therapy is required by patients who have lost the use of their intestinal tracts and involves administering nutrients each day through an in-dwelling catheter by means of a volumetric infusion pump.

Enteral therapy is required by patients who have a functioning intestinal tract but for whom regular oral feeding is impossible. Enteral therapy is administered through nasogastric, jejunostomy or gastrostomy feeding tubes by means of an electronic flow controller or by gravity.

The services, supplies, and equipment commonly used in parenteral/enteral therapy include the following:

A. Services

(1) Consultation with hospital personnel in establishing the patient protocol fo home therapy.

(2) The provision of home training in the hospital if necessary.

(3) Additional instruction in the patient's home at the time of discharge from the hospital.

(4) The provision of all equipment and supplies, including parenteral or enteral solutions.

(5) Registered pharmacists and nurses on call at all times to meet patient needs.

(6) Delivery of all solutions and equipment to the patient's home.

(7) Periodic follow-up by nurses and pharmacists, to assure patient compliance with the home regimen.[2]

B. Supplies and Equipment

(1) Catheters
(2) Filters
(3) Extension Tubing
(4) Infusion Bottles
(5) Pumps (either food or infusion)
(6) I.V. Poles
(7) Needles
(8) Syringes
(9) Dressings
(10) Tape
(11) Heparin Sodium (parenteral only)
(12) Volumetric Monitors (parenteral only)
(13) Concentrated Nutrients
(14) Enteral nutritional preparation
(15) Liquid Diet (for catheter administration)[3]

Parenteral and enteral nutritional services, supplies, and equipment have been "ordinarily furnished" by hospitals to inpatients for many years and, accordingly, they have been covered under Part A of the Medicare program as hospital inpatient services since 1976.[4] At least until 1981, HCFA permitted parenteral and enteral therapy service furnished in the home setting to be covered under the home health benefit.

In July 1981, HCFA issued revisions to the Medicare Carriers Manual which stated that parenteral and enteral therapy equipment and supplies furnished in other than the hospital inpatient setting were to be covered under Part B of the Medicare program as "prosthetic devices."[5]

In a memorandum dated July 26, 1982, HCFA stated that parenteral and enteral therapy, supplies, and equipment could not be covered as prosthetic devices if the patient's functional impairment is likely to be temporary rather than permanent in nature.[6] Accordingly, these Manual provisions and the July 26, 1982 policy memorandum appear to be the sources of the recent interpretations by HCFA and the Texas intermediary.

II. Legal Analysis

A. Parenteral/Enteral Therapy is Covered as a Home Health Service

(1) Coverage as home health "medical supplies" or "medical appliances"

HCFA's position that parenteral and enteral therapy services cannot be covered as "home health services" because they are covered exclusively as prosthetic devices is inconsistent with Medicare law and HCFA's own

prior interpretations of the law. In fact, parenteral and enteral therapy services are covered as home health services if they meet the criteria for coverage and are not expressly excluded from coverage by some other provision of Medicare law.

"Home health services" are covered under Title XVIII of the Social Security Act. 42 U.S.C. Subsection 1395d(a)(3) and 1395k(a)(2)(A). The term is defined to include "part-time or intermittent nursing care" and "services of home health aide," "medical supplies (other than drugs and biologicals)," and "the use of medical appliances." 42 U.S.C. Section 1395x(m)(1), (4), and (5); 42 C.F.R. Section 405.236(a), (d) and (e).

According to HCFA's instructions, "medical supplies" means:

> Items which, due to their therapeutic or diagnostic characteristics, are essential in enabling home health agency personnel to carry out effectively the care which the physician has ordered for the treatment or diagnosis of the patient's illness or injury.

Home Health Agency Manual Section 206.3.A. Examples of items which HCFA considers to be "obviously" medical supplies are catheters, needles, syringes, surgical dressings, adhesive bandages, materials used for dressings such as cotton gauze, and materials used for aseptic techniques. Id. Other items which HCFA also considers included within the term "medical supplies" are irrigating solutions, intravenous fluids, and oxygen. Id. Thus, the supplies which HCFA has identified as being ordinarily provided in parenteral and enteral therapy are either explicitly or implicity included as medical supplies under the home health benefit.

The equipment needed to administer parenteral and enteral therapy in the home similarly falls within the definition of home health services. According to HCFA's instructions, medical appliances which may be covered as a part of home health services include items of medical equipment:

(a) owned or rented by the home health agency;

(b) placed in the patient's home to facilitate his treatment and rehabilitation under a home health plan;

(c) capable of withstanding repeated use;

(d) primarily and customarily used to serve a medical purpose; and

(e) generaliy not useful to a person in the absence of illness or injury.

Home Health Agency Manual Section 206.3(B). Infusion bottles, I.V. poles, volumetric monitors, and infusion pumps, which HCFA acknowledges are ordinarily furnished in parenteral and enteral therapy,

clearly would be included in the definition of medical appliances set forth in the Home Health Agency Manual.

(2) Parenteral and enteral therapy services, supplies, and equipment are not excluded from the home health benefit

Items and services which are encompassed within the definition of home health services are covered under Medicare if certain conditions for coverage are met. The patient must be under the care of a physician and confined to his home. 42 U.S.C. Section 1395f(a)(2)(D); 42 C.F.R. Section 405.234; Home Health Agency Manual Section 208. The items and services must be furnished by a participating home health agency or by others under arrangements made by the home health agency; they must be furnished under a plan of care; and they may not be expressly excluded from coverage by some other provision of Medicare law. Id.

Items and services which are expressly excluded from covered home health services are:

(a) items and services which would not be covered as inpatient hospital service if they were furnished by a hospital,

(b) transportation services, and

(c) housekeeping services.

42 C.F.R. Section 405.237. Items and services furnished by a hospital to inpatients qualify for coverage as inpatient hospital services if they are the types of items and services which are ordinarily furnished by a hospital to its inpatients. See 42 C.F.R. Subsection 409.14 and 409.16. HCFA has acknowledged in regulations and in reports that parenteral and enteral therapy services, supplies, and equipment are ordinarily provided by hospitals to their inpatients. 42 C.F.R. Section 405.310(m)(2)(v); Home Parenteral and Enteral Nutrition Support Services, 1. Thus, the parenteral and enteral therapy services, supplies, and equipment which are commonly provided to patients in their homes do not fall within any specific exclusion from the home health benefit.

There are general exclusions for a variety of services which are otherwise covered under Medicare such as: services which are not reasonable and necessary for the diagnosis and treatment of illness or injury or to the functioning of a malformed body member, custodial care, and personal comfort items, among others. 42 U.S.C. Section 1395y(a); 42 C.F.R. Section 405.310. So long as parenteral and enteral therapy services, supplies and equipment meet the definition of home health services and do not fall within one of the specific or general exclusions to coverage, those services should be covered under Medicare as "home health services."

Significantly, and unfortunately for HCFA's postion, there is no provision in the statute or regulations which would permit denying coverage under the home health benefit merely because parenteral and enteral therapy services, supplies and equipment are also covered under Part B of the Medicare program as prosthetic devices.

B. Significance of HCFA's Position

HCFA has taken the position in instructions and policy memoranda that parenteral and enteral therapy services, supplies and equipment are covered exclusively as prosthetic devices.[7] Prosthetic devices are one of the types of items included under the category of "medical and other health services" covered under Part B of the Medicare program. 42 U.S.C. Subsection 1395k(a)(1) and 1395x(s). Covering parenteral and enteral therapy items and services exclusively as prosthetic devices has several significant consequences. Medicare reimburses only 80% of the reasonable charge for prosthetic devices but 100% of the reasonable cost or reasonable charge for home health services. There is an initial deductible amount which Medicare does not pay for prosthetic devices and are not reimbursed (except to the extent the costs are contained in the reasonable charge for the items supplied) while part-time or intermittent nursing care is covered under the home health benefit. Finally, prosthetic devices are covered according to HCFA instructions, only where they replace all or part of the function of a "permanently" inoperative or malfunctioning internal body organ while home health services may be covered if they are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. 42 U.S.C Section 1395y(a)(1)(A).[8] Thus, acknowledgment by HCFA that parenteral and enteral therapy services are covered as home health services will result in those services being more accessible to a greater number of patients outside of the hospital setting.

C. Deficiencies in HCFA's Policy

HCFA's position with respect to parenteral/enteral therapy is deficient in the following ways:

(1) As discussed, the policy has no support in the law pertaining to the coverage of home health services.

(2) It represents a reversal of HCFA's policy with respect to services covered under both Part A and Part B of the Medicare program.

(3) It is inconsistent with HCFA's own instructions.

(4) It is inconsistent with HCFA's prior interpretations and practice.

(5) It violates the rulemaking provisions of the Administrative Procedure Act and the provision of Executive Order 12291 and the Reduction of Paperwork Act of 1980.

(6) It is contrary to public policy and HCFA's objective of reducing costs under the Medicare program.

In addition to lacking support in the rules defining coverage of home health services, HCFA's position represents a reversal of its prior policy with respect to concurrent coverage of services under more than one provision of the Medicare program. Many patient services can be covered under more than one provision of Medicare. For example, "home health services" are covered under both Part A and Part B.[9] Many of the specific items and services covered under Part B as "medical and other health services" are also included in the definition of "home health services" (e.g., diagnostic services,[10] outpatient physical therapy and speech pathology services,[11] durable medical equipment,[12] and surgical dressings.[13]) Perhaps most significantly, many of the items and services included within the definition of "prosthetic devices" under the medical and other health services benefit are also expressly included under the home health benefit (e.g., catheters, needles, syringes, dressings, and tape).[14]

In the past, HCFA has taken the position that if the patient is eligible for coverage of home health services under both Part A and Part B of the Medicare program, coverage and payment will be deemed to be under Part A. Home Health Agency Manual Section 208.3. Where services could be covered as home health services under Part A and as medical and other health services under Part B, HCFA has permitted the patient to choose the coverage he desires. 42 C.F.R. Section 405.239 and Home Health Agency Manual Section 222. Accordingly, HCFA's recent position that parenteral and enteral therapy services may be covered only as presthetic devices under the medical and other health services benefit is a dramatic reversal of its prior policy.

A recent report indicates that HCFA recognizes that its policy with respect to coverage of parenteral and enteral therapy services is internally inconsistent. The HCFA Chicago Regional Office stated in a report dated March 1, 1983 that Section 2130 of the Medicare Carriers Manual defines prosthetic device to mean a device that replaces a "permanently" inoperative or malfunctioning body organ while the Medicare Carriers Manual Coverage Issues Appendix Section 65-10 "clearly acknowledges the therapeutic potential and possible temporary nature or parenteral and enteral therapy."[15] The report observes that the Coverage Issue Appendix lists numerous diagnoses which are not permanent conditions (e.g., jaw fracture) and numerous chronic conditions for which parenteral and enteral therapy may not be needed permanently (e.g., acute ulcerative colitis) as diagnoses and conditions which would warrant the use of covered parenteral and enteral therapy services. The report also notes that the relevant medical literature supports the concept that parenteral and enteral nutrition therapy is appropriate on a temporary basis to accelerate healing and recovery from certain conditions.

Further, according to a survey conducted by the HCFA Chicago Office, most carriers have been relying upon the broader coverage described in the Coverage Issues Appendix rather than on the more narrow coverage conditions contained in the Manual definition of prosthetic devices. The Chicago Regional Office, therefore, concluded:

> The instructions provided in the Medicare Carriers Manual are ambiguous and provide ineffective guidance.

Home Parenteral and Enteral Nutrition Support Services, Executive Summary, 1.

In addition, the survey conducted by the Chicago Regional Office revealed that many carriers are reimbursing parenteral and enteral therapy services, supplies and equipment under the home health benefit. A letter from the HCFA Office of Coverage Policy to the Blue Cross/Blue Shield Association as recently as August 9, 1983 referred to "two Bureau reponses indicating coverage for related nursing services and hyperalimentation supplies under Medicare's home health benefit." (Attachment B). Finally, the recent newsletters from the Texas state-wide intermediary states that because parenteral and enteral therapy may be used to treat a <u>permanent</u> impairment, the therapy cannot be covered as a home health service; however, nursing services involved in "teaching visits for short-term enteral therapy may be covered as home health services." (Attachment A). Thus, conflicting instructions from HCFA have resulted in arbitrary and capricious coverage policies and decisions by the intermediaries.

Even assuming that HCFA corrects the inconsistencies in its instructions and fully implements its more restrictive policy with respect to coverage of parenteral and enteral therapy services, it may not do so without complying with the rulemaking requirements of the Administrative Procedure Act as explained in D below.

Finally, covering parenteral and enteral therapy services exclusively as prosthetic devices is contrary to public policy and creates incentives for higher costs to the Medicare program. The HCFA Regional Office concluded after studying the issue:

> It is clear that the therapeutic and/or life-sustaining value of total nutritional support should be available to more patients than the prosthetic device benefit would allow.

Home Parenteral and Enteral Nutrition Support Services, 20-21. Under HCFA's new policy, patients in need of parenteral and enteral therapy who cannot meet the prosthetic device coverage requirements will have to go without the services or receive them as hospital in-patients. Even the patients who are able to meet the prosthetic device coverage requirements will be penalized by having to pay the deductible and twenty percent co-insurance amounts for Part B services.[16]

HCFA's policy is contrary to the objective of reducing costs of services to the Medicare program because it has the effect of driving more patients to receive the needed services as in-patients of hospitals where the cost of therapy is recognized to be more than twice the cost of the same therapy provided in the home setting.[17]

HCFA's policy is contrary to the objective of reducing costs of services to the Medicare program because it has the effect of driving more patients to receive the needed services as in-patients of hospitals where the cost of therapy is recognized to be more than twice the cost of the same therapy provided in the home setting.[17]

HCFA's policy is sound to the extent that it broadens Medicare coverage to include prenteral and enteral therapy as a prosthetic device because it permits coverage of the services, supplies and equipment when redered by suppliers. However, there is no legal or public policy rationale to support the proposition that coverage of prenteral and enteral therapy services, supplies and equipment as prosthetic devices precludes their coverage as home health services.

D. HCFA's Policy Violates the Rulemaking Requirements of the Administrative Procedure Act

HCFA has acknowledged ininternal documents that its policy reverses its prior interpretation of the law and will affect the rights of many beneficiaries in home health agencies.[18] It is well established that changes in existing interpretations of the law and changes in policy which will have a substantial impact on the rights and interests of private parties, must be promulgated in accordance with the rulemaking requirements of the Administrative Procedure Act, 5 U.S.C Section 553. National Associaton of Home Health Agencies v. Schweiker, 690 F. 2nd 932 (D.C. Cir. 1982), cert. denied, 103 S.Ct. 1193, ___ U.S. ___ (1983); Batterton v. Marshall, 648 F. 2d 694, 708-09 n. 83 (D.C. Cir. 1980). Accordingly, whatever policy HCFA ultimately adopts, that policy cannot be validly implemented without being published in the Federal Register with an opportunity for public comment.

We are available to meet at your convenience and hope you will honor our request to meet as soon as possible.

Sincerely,

Val J. Halamandaris
President

FOOTNOTES

(1) A Research Paper: Home Parenteral and Enteral Nutrition Support Services, Operational Review Branch, Division of Health Standards and Quality, Health Care Financing Administration, Region V, (March 1, 1983), 1.

(2) Home Parenteral and Nutrition Support Services, 11.

(3) Medicare Carriers Manual Section 2130.A.

(4) Home Parenteral and Enteral Nutrition Support Services, 1 and 3; 42 C.F.R. Subsection 409.14 and 409.16.

(5) Medicare Carriers Manual Section 2130.A and Coverage Issues Appendix Section 65-10.

(6) Office of Coverage Policy, Bureau of Program Policy, HFA, Memorandum, Prosthetic Devices, July 26, 1982.

(7) Medicare Carriers Manual, Coverage Issues Appendix Section 65.10, Office of Coverage Policy, Bureau of Program Policy, HCFA, Memorandum, Prosthetic Devices, (July 26, 1982); Office of Coverage Policy, Bureau of Program Policy, HCFA, Memorandum, Parenteral and Enteral Nutritional Therapy (Oct. 26, 1982); Letter from Robert Streimer, Director, Office of Coverage Policy, Bureau of Eligibility, Reimbursement and Coverage, HCFA (Aug. 9, 1983) (Attachment B).

(8) The "permanent" requirement for coverage of prosthetic devices is not set forth in the statute or regulation but appears only in the HCFA instructions. Compare 42 U.S.C Section 1395x(s)(8) and 42 C.F.R. Section 405.231(h) with Medicare Carriers Manual Section 2130.

(9) See 42 U.S.C. Section 1395d(a)(3) and 42 U.S.C. Section 1395k(a)(2)(A).

(10) Compare 42 U.S.C. Section 1395x(s)(C) and 42 C.F.R. Section 405.231(k) with 42 U.S.C Section 1395x(m) and 42 C.F.R. Section 405.236(g).

(11) Compare 42 U.S.C. Section 1395x(s)(D) and 42 C.F.R. Section 405.231(m) with 42 U.S.C. Section 1395x(m)(2) and 42 C.F.R. Subsection 405.236(b) and 405.239.

(12) Compare 42 U.S.C. Section 1395x(s)(6) and 42 C.F.R. Section 405.231(g) with 42 U.S.C Section 1395x(m)(5); 42 C.F.R. Secton 405.236(e) and Home Health Agency Manual Section 206.3.B.

(13) Compare 42 U.S.C. Section 1395x(s)(5) and 42 C.F.R. Section 405.231(f) with 42 U.S.C. Section 1395x(m)(5); 42 C.F.R. Section 405.236(e) and Home Health Agency Manual Section 206.3.A.

(14) Compare Medicare Carriers Manual Section 2130.A with Home Health Agency Manual Section 206.3.A.

(15) Home Parenteral and Enteral Nutrition Support Services, 13.

(16) Even HCFA recognizes that coverage of items and services under Part B rather than under Part A as home health services is "disadvantageous to the beneficiary." Home Health Agency Manual Section 222.

(17) Home Parenteral and Enteral Nutrition Support Services, 2.

(18) See letter of August 9, 1983 from Director, Office of Coverage Policy, HCFA, stating that the new policy "supersedes" the prior policy permitting coverage of parenteral and enteral therapy services under the home health benefit. (Attachment B) See also Home Parenteral and Enteral Nutrition Support Services, 2-3, 12.

Blue Cross
Blue Shield
of New Mexico

Federal Medicare
Intermediary

12800 Indian School Road, N.E.
Albuquerque, New Mexico 87112

Medicare

Claims & Benefit Information 505/292-2600
Customer Services 505/292-2600
General Administration 505/293-0240

MEDICARE NEWSLETTER 83-48

October 15, 1982

TO: All Medicare Certified Home Health Agencies

FROM: Medicare Division

SUBJECT: Coverage of Parenteral/Enteral Nutritional Therapy Provided by Home Health Agencies

Long term parenteral/enteral nutritional therapy, required because the patient's digestive system is permanently impaired, is not covered under the Medicare home health benefit.

Where a medical judgement is made upon initiation of treatment that a patient's condition is not temporary, the supplies and nutrients necessary for the parenteral/enteral therapy would be classified as a prosthetic device and may be covered as a "medical and other health service" under Medicare Part B. Prosthetic devices are not covered under the home health benefit and must, therefore, be billed on the HCFA-1483.

Teaching visits for short-term enteral therapy (digestive system not permanently impaired) may be provided under a Medicare home health plan of treatment if the service meets the intermittent criteria as well as the other requirements for coverage under the home health benefit. Short-term enteral therapy supplies and accessories do not qualify for coverage under the prosthetic benefit because the patient is not permanently impaired. Supplies necessary to carry out teaching visits under a home health plan of treatment for short-term therapy are limited to those items classified as home health medical supplies (see HIM II, Section 206.6). The nutrients are not covered as a medical supply under the home health benefit. The items not covered include prescription food, baby food, instant breakfast formulas, dietary supplements, etc

CAN'T WAIT FOR STUDY RESULTS

Senator DURENBERGER. Let me make an editorial observation and at the end ask you a couple of general questions. HCFA has a book about that thick that I finally read a couple months ago, when we had a long recess. It has a red cover. On the inside it has a description of hundreds and hundreds of studies. And my frustration, as I was going through it, is that we don't have time to wait 5 years to find out how to reimburse home health agencies, whether you look at it in terms of the costs that we are giving to you or whether you look at it in terms of our colleagues who just want to rush in and cut another $20 million out of medicaid, or whether you look at it from the standpoint of people out there who know how to do home health or who know how to do some of these others.

I don't think I want to wait 5 years to find out how to solve this problematic part of it. And I hear what you are saying. What you are really saying is, "Don't goof it up. Don't give us something in your well-intentioned Washington manner that wastes about half of the money, in terms of patient care." That is in no way picking on your testimony, but by way of observation on a lot of these studies. We are running out of time.

SUPPORT FOR PEER REVIEW

One question, Dr. Jordan. You heard my questions of Dr. Helms about peer review and so forth. I raise them here, even though I know the answers before I raise the questions, because I need to know from you how the physicians in New Mexico feel about alternatives to physician peers. There are some people that strongly suspect that this administration—well, they know that some people in the administration—don't want peer review at all. Forget it. The others think that the insurance companies and some of these other companies can do it just fine, because there are some examples where they have done some good utilization.

But, given the issues you raised about how to balance the dollar pressure against the quality of care pressure, all of that falls either on your shoulder or the hospital administrator or some combination. I wish you would, just for the record, tell us some of your feelings and that of your colleagues about the importance of peer review in this whole system.

Dr. JORDAN. Thank you. The New Mexico Society feels the peer review should be performed by peer review organizations sponsored by physicians and that the New Mexico Medical Society supports the New Mexico Medical Review Association's application to be the peer review organization for New Mexico for medicare patients. So we feel strongly that this should be done by peers. We want to look, yes, at the cost, and the utilization factors, but we think that we are the ones who can more assure that the quality is there as well as the cost effectiveness.

EXCLUDE DOCTORS' FEES FROM DRG'S

Senator DURENBERGER. Have you given some thought to what I said earlier, I think, in my opening statement about how quickly

this concept of DRG might be responded to, to include Dallas' programs and skilled nursing facilities, from which we will hear shortly, and doctors?

Dr. JORDAN. I am disconcerted that it might go on to doctors. I have a little trouble trying to figure out how the DRG can be applied to payment for services rendered by physicians, because it varies so much. Because very few patients will be labeled by a diagnosis. Patients come to see doctors for problems, for pain, for this, that, and the other, and you may or may not be able to tie a diagnosis to it. That is a little different, I think, from going to the hospital where a patient has a principal diagnosis or admitting diagnosis or discharge diagnosis or various other things that we can put a handle on. I think it would be difficult, particularly in the outpatient setting, to use the DRG's.

And as a radiologist, I guess, I am concerned in several areas related to how the patient will be reimbursed for charges I make to them for services we render.

DON'T MOVE TOO FAST ON HOME HEALTH CARE CHANGES

Senator DURENBERGER. Let me bridge over to Dallas' comments, too, in that regard. Some of the testimony that we heard in November and December and before my subcommittee on the future of long-term care and the role that skilled nursing and home health and so forth would play, a lot of testimony was, "Don't move too quickly to help us out." I know what you are talking about here in terms of the intermediary and so forth, however, it is a slightly different issue.

But one of the things that we are hearing from around the country from State and local people is:

> Don't move too quickly on trying to create a whole new home health program or a whole new system. We at the local level are trying to experiment with community-based services. And we would like a little bit of time to tell you, if you are going to play a role in financing it at the Federal level, who should be making these decisions, who should be helping people to make the decisions, and how they should be financed.

What are your reactions, Dallas, generally, to the problems we face and whether we ought to be rushing into them with a new Federal program?

Mr. RYCHENER. As you said, I think one of our primary concerns is that we don't move too fast, that we don't get the cart before the horse, which I think is sort of what happened, as an example, with the hospice program. And in the payment system, the amount of payment was determined, really, before all of that data was analyzed and put together, even. I think that is our first concern.

Second, if a system is instituted for home health care, whenever that is, that at least it be based on some reliable scientific information, that the industry be involved and can live with the end product as well as HCFA can live with it. That gets back to the other problems of what is happening with HCFA in terms of some of the decisions that are being made without industry input that are affecting our agencies greatly without their having any say about it.

HOSPITALS AND OTHERS IN HOME HEALTH CARE

Senator DURENBERGER. Is there something wrong with hospitals or skilled nursing facilities going into the home health business? Is that implicit in your testimony or are you sort of raising a flag that independent agencies are going to get cut off from referral?

Mr. RYCHENER. I am not giving any value judgment to it at all. I am saying that is an anticipated impact of the prospective payment system. I think some of that competition is good in some instances, some is not good. It depends on the local situation and the home health market that's there, whether or not the competition is going to be valuable or a disservice to the community itself.

Chairman DOMENICI. Thank you very much. Let me ask you, with reference to the intermittent care and HCFA that you have expressed here, that I guess we have been working on for about 1 year and a couple months in terms of the overall delivery system that you are involved in testifying about that we need here in New Mexico and nationally, how serious is that one problem?

Mr. RYCHENER. I think it is becoming more serious all the time.

Chairman DOMENICI. Can you quantify it; tell us something that we understand?

FIVE-DAY SERVICE NOT INTERMITTENT

Mr. RYCHENER. Right now in New Mexico, the latest memo that we have received from our intermediary here regarding home care is essentially that any service that is provided 5 days or more per week is considered not intermittent. And you know we certainly have patients who require daily care for short periods of time. And I think our concern is that the magnitude of those patients, the number of those patients, are going to increase significantly with the advent of prospective payment, when it gets into full force here in New Mexico. And I think our main problems with that issue are still on the horizon.

Chairman DOMENICI. So it could be a major one in home health care in the future, as you see it?

Mr. RYCHENER. Yes.

HOSPICE CARE

Chairman DOMENICI. You made a point that, if I understood you right, we might have moved too rapidly with hospice because there are some problems there, is that what you said?

Mr. RYCHENER. My comment was that part of the regulatory process and the payment system was developed a little rapidly, yes, without as much input as there probably should have been.

Chairman DOMENICI. In all honesty, there is so much pressure in the system not to change by other parts of the system, that I really think hospice, or whatever problems you found, is an excellent alternative, and we are helping a lot of people. Maybe it doesn't work as well for your particular delivery system to get into the job of doing it and being part of it, but you really aren't saying that the problems with hospice are more than the benefits that we get from it, are you?

Mr. RYCHENER. I think I would reserve judgment on that for a while. Certainly we support the hospice. Home health agencies have been providing similar services for a long time. Our main concern is that since the regulations were developed, the process of becoming a hospice program, of getting certified, has become so restrictive that even many of the hospice programs that have been in existence are concerned about whether or not they will be able to survive under those regulations.

MOVE ON HOME HEALTH CARE CHANGES

Chairman DOMENICI. With all respect to your conclusions and your asking us to wait, my experience has been that if we have a chance to move in some area of home health care we ought to do it and we ought to—I regret to tell you—learn with the experience, because most of the time if we wait around until everybody has given us their views, as the Senator indicated, it takes forever.

Frankly, I am not sure that we learn too much in the program by waiting. It is a pressure system. We will have to put different things in and try them. For a long time, Dave, even a couple years before you arrived on the scene, for any addition to the delivery system, they would come up and tell us to expand home health care and would say the reason is, it is cheaper and it does the job better, and it is more like what we really like.

And all we got out of administrators was that it cost more because all the existing programs remain in place and whatever you add for this is that much more. We couldn't convince anyone that we were talking about 20 years and a fix. And if a piece of the fix is cheapter and does the same job, eventually, if you are not overutilizing, eventually you get a more realistically priced product. We had to act on part of home health care just because the iron was hot and we had to strike and do something, I think is the truth.

I think we will make a lot of mistakes in these changes. We need your input and information and we are aware of the fact that each of the present delivery systems has a vested interest in leaving it as much alone as possible. And you may even be saying that.

GIVE THOUGHT TO CHANGES

Mr. RYCHENER. I did not mean to imply that we at home health care are not willing to do our part in seeking solutions to these problems. Certainly we don't intend to sit on our hands in the next 5 years and wait for that project to be completed, but our concern, again, is that there be a lot of thought given to the system that is put in place, especially in light of the fact that there is a very limited data base on home health care nationally, which the Department of Health and Human Services has admitted they are essentially at the point now where they were 10 years ago with the hospital industry, as far as reliable data.

Chairman DOMENICI. You know, and your people who work for you and with you know, that what I have been saying is in no way an indication of anything other than an advocate of home health care in the total mix, and I am convinced it is going to do a better job than some of the other institutional approaches.

ECONOMIC REWARDS TO PHYSICIANS

Let me move to Dr. Jordan for 1 minute. Doctor, there is a recent Wall Street Journal article indicating that hospitals are beginning to provide what this article called economic reward to physicians whose patient-care decisions help restrain the hospital expenses. It goes on to say, "Since prospective payment caps a hospital reimbursement they are acutely aware of the potentially devastating fiscal impact of overutilizing physicians." Now, that is the Wall Street Journal, quoted verbatim.

I just want to ask you. I assume you agree that there could be overutilizing physicians?

Dr. JORDAN. Yes. Overutilizing in the fact that, yes, they may have ordered too many tests or seen too many consultations and so forth, yes, sir.

Chairman DOMENICI. If there is, and it is a problem, and I know that you feel that way because you have told me that before when we talked about it, and you are very concerned about it, you just want to make sure it is done right, and that the peer people do it, and we don't hurt the patient in the process. But you clearly told me you don't think that everything is as precise as a peer review group would have it. But are these kinds of arrangements where a hospital is going to be doing this, is that going to work? And do you think it is starting in New Mexico? How is that going to have an impact?

Dr. JORDAN. Well, I really find that difficult to accept, for one thing, and, No. 2, I don't think it is starting in New Mexico that I am aware of. As I said earlier, I have been all over the State talking to just about all the doctors in the county medical societies. I am not aware of anything in that regard. I really think, Senators, that the hospitals and physicians have to work together. And it is our intent that we will try to make the DRGs prospective payment system work effectively so the hospitals and patients will not be hurt. I see my own bias right now. I don't see financial incentives being given to physicians for not ordering this and not doing that. I don't see that.

DOCTORS AND HOSPITALS HAVE COMMON INTEREST

Chairman DOMENICI. Well, I bring it up because you are the president of the largest group of doctors in New Mexico, and, obviously, if our evidence is correct that as much as 75 to 80 percent of the hospital costs are directly the result of what the physician orders—I am not saying you cause the individual costs, but they do what you tell them—and that equals 75 to 80 percent of the ultimate bill, it seems to me if the DRG's and prospective payments are going to work where somebody is setting the price for the entire episode, it seems you are going to have to work with the hospital for the whole thing. I don't understand how it has a chance of working.

Dr. JORDAN. You are absolutely correct. We have a vested interest in working with the hospitals so that the hospital will survive and provide services for our patients. We see the hospital as the place where we take care of our patients. We cannot survive with-

out the hospital and the hospital cannot survive without the physicians, so we have to have a working relationship.

And this is some of my comments in that I know there are going to be some stresses between the medical staff and the hospital administration, and we hope that we can address them and try to keep the stresses working in a positive manner to make this work.

GETTING READY FOR NEW PLAN

Chairman DOMENICI. Now it seems to me that I am compelled to ask you the next question because you are the chief honcho in disseminating information. You already said that it is not starting at all. Might I ask you, when are you going to initiate a process wherein more of the doctors start doing this, getting ready for it? Shouldn't you even be here saying, "We are going to work hard in trying to do it, Senators. We have got some things in the mill where the doctors are beginning to get wound up on this and being helpful"?

Dr. JORDAN. We are doing that. Maybe I misunderstood. I thought you were asking me is it starting where hospitals give doctors incentives to get the patients out of the hospital. I thought that was it.

Chairman DOMENICI. I know that is going to happen. They say it is going to happen.

Dr. JORDAN. Doctors in New Mexico are gearing up. I bought this national medical advisory service so that I could learn more about DRG's. They are extremely complicated. Oh, yes, we are already starting up, trying to learn how to code the chart correctly, how to make sure that proper information is there so that they can be coded. You bet we have already started that. I misunderstood what you said.

Chairman DOMENICI. Do you know from your previous hearings whether this incentive that they spoke of in that newspaper is happening anywhere, Dave?

Senator DURENBERGER. No. We raised that with the California Medical Association, or they raised it with me, because there is a lot of discounting going on in California. They said, "This is something you have got to watch out for," for the same reasons that you pointed out in your testimony, "because of the effect on the quality of care" but they didn't give me any examples that some hospitals were actually doing it.

Chairman DOMENICI. Thank you very much. We are going to take a 5-minute recess. Everybody can stretch and we will get the next panel in shape to start.

[Brief recess.]

Chairman DOMENICI. I think we will go ahead. We want to finish this panel before we take our lunch break. When we recess, we will recess until 2 p.m. We have three panelists here that furnished the committee with a very diverse area of involvement and expertise. We are going to start with Howard Shaver, executive director of the New Mexico Hospital Association.

It is good to have you here. It has been a good experience to relate to your organization over the years since I have been a Senator, and I am very pleased to say that you have given us plenty of

good information to act on and that I found that you and your association have a very deep understanding of the health delivery system and I am pleased that you are going to share your view with us today.

STATEMENT OF HOWARD M. SHAVER, PRESIDENT, NEW MEXICO HOSPITAL ASSOCIATION

Mr. SHAVER. Thank you, Senator. We welcome the opportunity to provide some more input to you. We have limited our testimony today to the prospective payment system and have not dealt with the broader realm of health care financing. And, Senator Durenberger, we want to thank you for being here, too, and appreciate the leadership you have provided us in bringing us prospective payment. We, as an association, have been supportive both at the local level and the national level of prospective payment, and think there are some real opportunities there.

PRIVATE-PAY PATIENTS CAN BE AFFECTED

Clearly, prospective payment means big changes, not only for medicare but we believe it is going to have a significant impact on the delivery of health care services to private-pay patients, because clearly as you economize and change the practice of delivery to medicare patients you can't help but have a significant impact upon the private patient, so that either the good or the bad that comes from this will affect all patients. Clearly we can't speak a lot about what has happened here in New Mexico. There are only two hospitals that went in, in October, a small hospital and a larger urban hospital. And then in January another rural hospital joined in. But we can give you some details.

HOSPITALS IN PROSPECTIVE PAYMENT PLAN

One hospital was St. Mary's Hospital in Roswell, a medium-sized hospital. It has seen some interesting things happen. It has had good cooperation from its medical staff and I might add that every one of the hospitals, both before going into it and those that are preparing to go into it, have conducted extensive educational programs for their staff, both medical and nonmedical, to look at what the impact will be and how things might change. The hospital in Roswell has actually seen a 2-percent increase in its payment for medicare as a percent of bill charges. With its very limited experience it went from 72 to 74 percent of bill charges being paid by the medicare program. I will let Dr. Ottensmeyer talk a little bit about the impact it has had on it.

CHOSE TO JOIN PLAN

The Sierra Vista Hospital in Truth or Consequences is a very small hospital that has some 70 percent of its patients today that are medicare when that went into the system in January. Clearly this system is going to have a profound effect on it. Although that hospital could have chosen to remain under the old system, since it is the sole community provider, it made the choice to go under this system feeling that the economies, the incentives that would exist,

would benefit the provision of care in that hospital. And I know the Senator is well aware of that hospital and the services it renders.

Chairman DOMENICI. How many beds?

PAYMENT LEVEL CRITICAL

Mr. SHAVER. I think it is less than 50; 25, 30, somewhere in that neighborhood. One thing that they are really looking at is they are keeping a very close track of quality assurance to make sure the quality of care afforded the patients does not suffer. And that is a concern that we do have. And it was spoken to already by Dr. Jordan. In New Mexico, with the exception of Albuquerque, Roswell and Raton, every other community that has a hospital only has one hospital, so that we are concerned that if the payment level is not adequate and fair it may create some real problems for that hospital to continue particular services, perhaps some expensive services, that are certainly needed by that community, because it may be 60 or 70 or 80 miles to another facility. That is a concern that I will talk about a little later.

PHYSICIAN-HOSPITAL RELATIONS GOOD

One thing that we have noted with those hospitals that are in the prospective payment system or are ready to go into it is that so far the physician-hospital relationship seems to be very good and there seems to be a gratifying and very positive response by the medical community to assure that this system is going to work. I think there were some predictions initially that perhaps some physicians would try to fight the system. So far that appears not to be happening. We are concerned that if the payment system doesn't change you are going to run into a real problem.

DURATION OF HOSPITAL CONFINEMENT DECLINING

It is clear that the incentives on the hospital part are different under a prospective payment system than the payment system the physicians are still under. We believe that is going to have to change rapidly. Clearly, the length of stay is something that will need to be dealt with. In New Mexico we have a very short length of stay and some initial experience would indicate that the length of stay is starting to drop already. There was some experience, I know, in a couple of hospitals in the reduction in length of stay even before we went under prospective payment. We think that will perhaps continue.

CHANGES IN CORPORATE FORMS OF CARE

Clearly there will be some changes in corporate forms of care. Some hospitals already have various components of care that they are providing, the urgent care center that the Senator mentioned, primary care through and including long-term care, and home care and hospice care. But whether or not that results in an ownership relationship, clearly there will be much longer linkages amongst the various levels of care regardless of the ownership, and there will be much more than the traditional transfer agreements of the

past. There will be some real contractual relationships, perhaps some risk sharing and some things like that, that we believe will be conducive to care.

An area that we have been conducting is swing bed. We think that has an opportunity in this State. And we are looking forward to continued operation of that. I would like to comment just briefly on some demographic factors in this State that are significant and have some real implications for medicare. That is the aging population. Between 1970 and 1980, the over-65 population in New Mexico grew by 64 percent. That is contrasted with New Mexico's overall population growth of 28 percent. So clearly there are some pressures on the length of stay, because clearly the elderly use a lot of health care services.

UNCOMPENSATED CARE

As we look at some areas of concern with the prospective payment system, the first area would be that of the uncompensated care. That is a major concern here in New Mexico. In 1982, some $106.3 million in uncompensated care was provided by community hospitals. By uncompensated care, I mean the difference between bill charges and what medicare and medicaid pays, the absolute indigent care, and an area of what is often referred to as self-pay. But it is somebody who has no insurance coverage, making $400 or $500 a month, and yet obviously has no ability to pay. And this has grown between 1980 and 1982 from some 19 percent of bill charges to almost 23 percent of bill charges.

And Bill Johnson, I believe, later will be talking specifically about the University of New Mexico. A recent study conducted by the University of New Mexico Bureau of Business and Economic Research indicated that some 22 percent of New Mexico's population is uncovered either through private insurance, through medicare, or medicaid. That contrasts with the national figure of some 12 to 13 percent of the population. So we have got a big problem here.

COVER UNCOMPENSATED

And what we would urge is that prospective payment recognize the cost of providing that service. Because, as you know, medicare in the past has not recognized bad debts as a part of doing business, other than medicare bad debts, which is a small part of the cost. Another item, of course, that we are concerned about is how capital costs are treated. In New Mexico, as Senator Domenici is aware, there has been considerable replacement of old hospital facilities, remodeling, and those kinds of things which have been necessary sorts of things.

As a result, capital costs are quite high here in New Mexico, in relation to other areas. The figures indicate that around 16 percent of the cost of doing business in hospitals in New Mexico is capital costs, so clearly whatever is done with capital costs is significant, not only for the capital expenditures that have already been made but clearly there are some facilities that will continually need to be upgraded to meet the needs in the future. So capital cost is an important item.

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WAGE AREA INDEX DISCRIMINATES

Another area that I will just touch on briefly is the wage area index and it tends to discriminate against small hospitals because of the way part-time employees are counted, as if they were full-time employees. In recognizing the differences in New Mexico, clearly this is a national system that regardless of what you do with some of the points we mentioned, there are going to be very difficult and unique circumstances that will arise, be they the hospital in Truth or Consequences or Tuncumcari or whatever, that general regulations just can't take care of.

We believe there needs to be an adequate appeal system to recognize different problems that are unique to that particular hospital and also to treat such issues as the whole issue of rebundled services. As you are aware, in the past, medicare paid the hospital and paid other people related to patients in the hospital, and rightly so. The DRG needs to cover the cost of everything that goes on in that hospital.

But there needs to be some adjustments for those things that were rebundled in the past and are now provided as part of the hospital services. Clearly what we are saying is that we believe very much in the incentives prospective payment. What we are concerned about is that the payment system be fair, that it be adequate, that it be equitable to provide the particular services that are needed by the patients and, second, to recognize that clearly part of the intent of DRG's was for the urban areas, for example, to let hospitals make choices and eliminate some duplication.

Obviously, the hospital in Truth or Consequences doesn't have a lot of choices about some services. They need to provide certain services. It is not necessary for them to provide highly sophisticated services. But there are some services that they must provide. So we very much support prospective payment. We believe it has some tremendous opportunities, but it also has some dangers and some of it is in specific details.

We have attached to our testimony considerable information about medicare utilization in New Mexico and you will note that in every category, New Mexico has a lower rate of utilization than comparable areas and the trends have tended to be positive. And then we do have some other detailed information on the last couple of pages regarding the uncompensated care problem which is a major problem throughout the State, and a greater problem in certain parts of the State with certain hospitals. We thank you very much and look forward to continued dialog with both of you as you struggle with these very important issues.

Chairman DOMENICI. Thank you very much.

[The full prepared statement, with attachment of Mr. Shaver, follows:]

EFFECTS OF MEDICARE CHANGES IN NEW MEXICO
TESTIMONY OF HOWARD M. SHAVER
BEFORE U.S. SENATE COMMITTEE ON THE BUDGET
ALBUQUERQUE, NEW MEXICO
FEBRUARY 15, 1984

My name is Howard Shaver. I am the President of the New Mexico Hospital Association which represents over 50 hospitals in New Mexico, with public, investor-owned, nonprofit, and multiple member systems. In 1982, these facilities employed almost 20,000 people, incurred expenses of over $580 million, and provided 1,686,026 days of patient care to New Mexicans. I appreciate the opportunity to testify before you today concerning the Medicare prospective payment system. Senator Durenberger, I welcome you to New Mexico and hope that you have a pleasant visit in our state. Senator Domenici, it is nice to see you again.

Introduction

Prospective payment for services to Medicare beneficiaries is the biggest change for hospitals since the advent of the Medicare and Medicaid programs in the mid-60's. We believe that prospective payment provides very sensible incentives for hospitals, rewarding economy, not consumption, of scarce resources. In my testimony today I will discuss generally (1) the economic impact of this program, (2) hospital practice changes, and (3) the rise of new corporate forms and the increase in linkages between different kinds of providers. Finally, I would like to explain briefly some of the modifications that I believe are needed and make some projections for the future. I will leave discussions of some of the very specific changes in hospital operation to my colleagues, Mr. Bill Johnson of the University of New Mexico Hospital and Mr. Dick Gillock of Lovelace Medical Center who will testify later.

General Economic Impact

At this time, it is hard to provide details of the economic impact of the prospective payment system on overall hospital revenues in New Mexico. Our information is limited due to the small number of providers with experience in the system. Two hospitals began participation in October and one in January. The majority will be on the system by July of 1984.

Experience of Hospitals Under PPS

St. Mary's Hospital in Roswell has had four months of experience under the prospective payment system (PPS). St. Mary's has seen a two percent increase in payments as a percent of charges for Medicare patients, from 72% to 74%. Medical staff have been extremely helpful in working with the administration to avoid unnecessary hospitalization and shorten length of stay. For example, the neurosurgeon at the facility worked out

a way for a patient with cancer to stay in the hospital's "family room" with a hired nurse while she received radiation treatments. The patient did not require hospitalization or skilled nursing care, but was not able to return home because of the physical isolation. Another positive effect of the new system is that this hospital is doing a rigorous review of all of its services and considering eliminating or scaling down those that are under-utilized.

Sierra Vista Hospital in Truth or Consequences began participation in the system in January. D. Rush, President of Sierra Vista Hospital, reports that preparing for prospective payment was a major undertaking. Monitoring systems in the billing, medical records and quality assurance areas were significantly redefined and reorganized. Heavy expenditures were made for educating staff at all levels. Particularly, medical and nursing staffs received training about how their functions need to change to provide care more economically through the team treatment concept, concentrating on the whole patient rather than emphasizing the parts that single providers play in the patient's care. Medical staff bylaws have been amended to require faster submission of finished charts. Additional medical records personnel have been added because of the importance of quick, accurate medical records monitoring and diagnostic related group (DRG) assignment. The hospital is very concerned about keeping close track of quality assurance, to be sure that the quality of care afforded patients does not suffer due to financial constraints. Although Sierra Vista Hospital could continue to receive reimbursement under the former system because it is a sole community provider, the hospital chose to participate in PPS. It determined that efficiency and other operational changes would be rewarded under PPS more adequately than under the TEFRA cost-per-case payment system.

Projected Changes in Hospital Operations

There will be profound changes in the way that care is delivered in hospitals. Our members see the relationship between physicians and patients and physicians and hospitals undergoing revolutionary change. Our members report a gratifying but not unexpected degree of interest, cooperation and help from their medical staffs in meeting the challenges of prospective payment. The experiences at the hospitals that I described above will probably be repeated time and again. The DRG system almost mandates cooperation among all providers of patient care. Physicians and hospitals are reevaluating treatment regimens for all major procedures and looking for the most cost-effective method of delivering high quality care. For example, doctors and hospital pharmacists are reviewing the kinds of drugs prescribed to patients, by DRG, and finding an enormous range of variance among physicians for patients with essentially the same condition. The result of reviews like this will be, we hope, adoption of the most cost-effective and medically-effective treatments possible.

There may be a less rosy aspect to the future of physician-hospital relations. Hospitals operating under the prospective payment system have incentives to keep costs as low as possible consistent with quality

care. Physicians, however, are still paid under the old system and we are concerned about the possibility that this cooperative team approach may run into difficulty when physician incomes are affected by lowering the length of stay, the amount of ancillary services ordered and thus the amount of "doctoring" done by doctors. We are all economic creatures, and we respond to the incentives that provide us the most benefit. Right now, physicians and hospitals have different economic incentives for treatment of their Medicare patients and we hope that this difference does not create tension between physicians and hospitals.

Reducing length of stay in the hospital is a major area of emphasis for our members. The average length of stay in New Mexico is already very low compared to the national length of stay. In the United States the average length of stay between 1980 and 1982 was consistently about 7.6 days. In the same period, the length of stay in New Mexico rose from 5.9 days to 6.7 days, still almost one day below the national average. However, trends in New Mexico indicate that the length of stay is dropping once again. Between January and October of 1983 the length of stay for medical and surgical patients in New Mexico dropped from 6.7 to 5.7 days or 17.5%, almost one full day in less than a year. The length of stay for all services dropped from 6.1 to 5.9 days, or 3.3%. In the same period, the occupancy rate in our hospitals dropped from 71.0% to 64.8%, a decline of 8.7%. We think this is significant, particularly in light of the increasing number of elderly people living in the state who require more frequent and longer stays during that same period.

There will be more emphasis on cheaper forms of care. For example, outpatient surgery is one way that hospitals can reduce the cost and the length of stay for their patients. In 1982, more than 100,000 surgical procedures were performed in New Mexico community hospitals of which more than 25,000 were performed on an outpatient basis. Standards are now being developed by the State Health Planning and Development Bureau to increase target rates for outpatient surgery to 30 and 40 percent. We support the rise of cheaper ways of delivering high quality care. However, we note that this emphasis may act as a two-edged sword. Such care is cheaper for the patient, but it will eliminate the historic subsidy provided to the truly expensive "loser" cases on which no hospital can make back its costs of care. Thus the overall intensity factor of cases in hospitals across New Mexico will increase. What this means is that we expect to see sicker inpatients as more alternatives are provided for those with less serious illnesses. This trend makes adequate payment for those who must be hospitalized even more important.

New Corporate Forms of Care

We expect to see new corporate forms develop. This change is referred to as vertical integration: a series of different levels of care owned, managed or used by the full-service hospital, from primary care services to the emergency center, outpatient surgery center, skilled nursing facility, intermediate care facility, home health care service and hospice.* Some hospitals may own some or all of the components of this expanded care system. Others will enter into cooperative agreements with other providers more formalized and sophisticated than the traditional

transfer agreements of the past. Discharge planning and placement will begin as soon as the patient enters the hospital. You are hearing today from representatives of the long term care industry and the home health care industry in New Mexico. We expect that relations between hospitals and these providers will be increasingly important.

In New Mexico, we are very excited about the potential offered by the swing bed program. The New Mexico Hospital Association is administering a four-year grant from The Robert Wood Johnson Foundation to help small, rural hospitals develop swing bed programs. We think that the prospective payment system increases the incentives for hospitals to get involved in this program, and we expect to see more facilities starting their own programs. In the swing bed program, the hospital bed is designated as a long term care bed when the patient's medical status so dictates. The Health Care Financing Administration has the authority to approve demonstration projects for larger or urban hospitals that are not statutorily eligible for the swing bed program. Swing bed offers another opportunity to match services needed by the patient with the appropriate medical setting and level of payment for services, and avoids some of the problems of transfers.

Demographic Trends

As other hospitals begin prospective payment, their financial experience will be guided in large part by the demographic trends in this state. In 1982, per capita hospital expenditures in New Mexico were $303, 67% of the national average of $452 per person per year. As a percent of total income, New Mexico's hospital expenditures are 3.4% as compared to 4.1% nationally. However, economic trends in New Mexico's healthcare picture indicate that the state is fast catching up with more urban and industrialized states. There are several reasons for this increase, which amounted to 300 percent between 1972 and 1982. A major reason is New Mexico's fast-growing Medicare population. New Mexico's elderly population increased 64% between 1970 and 1980, as compared to a 27% increase in the elderly population nationally. New Mexico's population in the same period increased by 28%, 2.5 times faster than the national increase of 11%. Almost 10% of the population here is over 65. This is bound to push hospitalization and other medical care expenses higher. People aged 65 to 85 are hospitalized twice as often as those under 65 years old, and those over 85 are hospitalized three times as often as those under 65. In addition to more frequent hospitalizations, the elderly have longer hospitalizations. For those under 65 the national average length of stay is about a week. However, the average length of stay for people aged 65 to 84 is ten days, and for those 85 and older the average stay is almost twelve days long. In short, the elderly population consumes nearly 33% of health care expenditures in the U.S. New Mexico's fast growing elderly population can be expected to need an ever-increasing proportion of our health care dollars. Please see Exhibit I, pages 1-4.

Suggestions for Modification

Some decisions have yet to be made in the prospective payment system, either by Congress or by the Health Care Financing Administration. The first area of concern to us is that of uncompensated care. One of our members told me recently about an individual whose situation illustrates one of the major problems with uncompensated care in New Mexico. This person is a self-employed farmer and rancher who lives in Guadalupe County. His wife has had two major heart surgeries and needs another. This individual cannot buy health insurance because of his wife's health problems, yet somehow care must be provided for her. In New Mexico, uncompensated care is an increasingly large share of each hospital's business. Mr. Bill Johnson of the University of New Mexico Hospital will tell you about the problems unique to his facility. Statewide, contractual allowances for the Medicare and Medicaid programs amounted to $54,350,000 in 1982. Individuals who simply could not pay and were not eligible for either Medicare or Medicaid accounted for $51,937,000 worth of hospital care in that period. Uncompensated care delivered by New Mexico's hospitals was $106,296,000 in 1982, or 22.6% of total net revenue. The uncompensated care component has increased by 85 percent since 1980, when the figure was $57,432,000, or 19.3% of total net revenue. A chart setting forth trends in uncompensated care in New Mexico from 1980 to 1982 is attached as Exhibit II.

New Mexico's uninsured population is huge. The working poor, who are ineligible for any public assistance for their medical expenses constitute almost 22 percent of the total population, according to information gathered by the University of New Mexico's Bureau of Business and Economic Research. This compares to 12-13 percent of the population without health insurance at the national level. These people tend to be younger, live in rural areas and be non-white. They suffer from periodic unemployment or from employment in low paying jobs which are less apt to provide health insurance as an employee benefit.

The result of this increasing uncompensated care load is that the paying patient base is shrinking in New Mexico. Hospitals need more and more local support to survive. Some hospitals in the state are drawing on their capital reserves to keep their doors open. As overall federal healthcare expenditures decrease, we are concerned with the impact of the reduced cash flow and increased bad debt load on hospitals that are already operating at the margin. We urge you to consider some method of recognizing and compensating for a fair share of the free care that New Mexico's hospitals are already providing.

We are concerned about the treatment of capital expenditures under the prospective payment system. This question has not yet been resolved by the Health Care Financing Administration, but New Mexico hospitals have extremely high capital costs due to the great deal of needed replacement, remodeling and updating that has occurred in the last five years. The average age of many facilities in this state was over 30 years. Replacement of facilities is required in order to meet licensing and certification standards and provide efficacious care to the community. Total capital expenditures by hospitals in New Mexico in 1982 were

$84,822,000 or 15.9% of total expenditures. We urge you to consider a fair system for reimbursing needed capital expenditures. Particularly, we are interested in compensation for those capital expenditures that were incurred under the previous system, and for a level of payment adequate to keep our healthcare facilities and equipment up to date.

The area wage index, an important component of the DRG payment, needs to be refined in several areas. We are particularly interested in a fair method of accounting for the wages of part-time employees in the total number of full-time equivalent employees. HCFA calculates the index by dividing total wages by number of employees, without accounting for the part-time worker. This results in an artificially low wage component, especially in rural areas which use many part-time workers. We suggest that the area wage index be calculated in a manner which accurately reflects the wages paid to full and part-time workers.

The current system does not permit appeals of HCFA decisions on three important issues. First, there is a need for flexibility in allowing hospitals with serious errors in their case-mix indexes to appeal such decisions. Second, hospitals should be allowed an opportunity to provide more accurate data as they assess the impact of having to pay for the "rebundled" Part B costs for which they are now responsible. A change to permit this would not increase Medicare outlays -- it would simply permit more accurate redistribution of Part B costs to Part A. Finally, hospitals must be able to resolve differences with intermediaries on base year cost reports. These 1982 cost reports were settled on an expedited basis to establish rates for 1984. The costs which would be appealed are not only legitimately incurred Medicare costs, but are also part of the TEFRA rate of increase limits and budget neutrality factor. Technical amendments permitting appeals of these important issues would result in a fairer system without appreciable cost increases.

We encourage the Congress to look at ways to facilitate movement of patients to the level of care that is most appropriate for their medical condition. I discussed the Swing Bed Program earlier; it is an example of a constructive way to help encourage lower cost levels of care. Financial incentives to move patients to the appropriate level of care as quickly as possible, such as assurance of payment and expedited mechanisms for required certification of the individual as eligible for a given level of care, will contribute to overall lowered costs by getting the patient out of the expensive hospital environment as quickly as possible.

Finally, the American Hospital Association is investigating the possibility of a Medicare price blending system on a DRG specific basis. Basically, what this would do is establish one single national rate for DRG's with very consistent costs across all providers, with a more hospital-specific rate for DRG's with very wide variations in cost that are not attributable to inefficiency, but rather to intensity factors. We are interested in investigating with the Congress methods for varying prices fairly within a budget neutral environment to reflect cost and efficiency of service. We would like to be able to develop a system that

would penalize the inefficient provider but not the efficient provider who may have high legitimate costs.

We are pleased that there will be periodic review of DRG rates by the Secretary's Commission. Fair rates, in our opinion, should include some recognition of the uncompensated care component and of capital costs, as we have discussed above. We understand that DRG's may require downward as well as upward adjustment as a result of technological and medical changes. Whatever is decided, the ratio of payment to cost must be adequate. If it is not, hospitals may not be able to afford to provide the service. If the question is, can New Mexico's isolated rural communities afford to do without these necessary services? If we can reach an adequate ratio of payment, we think that this system provides the opportunity to slow down the rate of increase in healthcare costs to a manageable level while providing needed services to small communities.

Conclusion

The New Mexico Hospital Association membership is generally supportive of the prospective payment system. What is needed now most is stability. PPS is an enormous change, and we strongly urge Congress to leave the system primarily as it is until its effects can be evaluated. Because the federal DRG model varies significantly from the New Jersey demonstration model, data obtained during the New Jersey study is not valid for purposes of comparison. Little hard data exists to substantiate the effects of the DRG system. Finally, I want to re-emphasize that the DRG rates must be fair. If the rates do not fairly reflect costs incurred, hospitals will be forced to eliminate treatment for those DRG's on which they cannot cover their costs. When inefficiency is the cause of the financial loss, we would hope that hospitals would eliminate that particular DRG. However, if the rates for a DRG are too low for any provider to cover its costs, few will be willing to assume the burden of consistently losing money on very expensive diagnoses, and thus the range of services available at community hospitals may shrink.

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MEDICARE UTILIZATION IN NEW MEXICO

	1980	1981	1982
Medicare Inpatient Days[1]	349,334	356,556 (2.07% increase)	380,199 (6.63% increase)
% of Total Inpatient Days[1]	36.63%	34.08%	33.31%
Medicare Admissions[1]	41,501	44,064 (6.18% increase)	45,355 (2.88% increase)
% of Total Admissions[1]	25.64%	26.24%	26.66%
Number of Medicare Eligibles[2]	111,205	115,312 (3.69% increase)	137,593 (19.32% increase)

SOURCES:

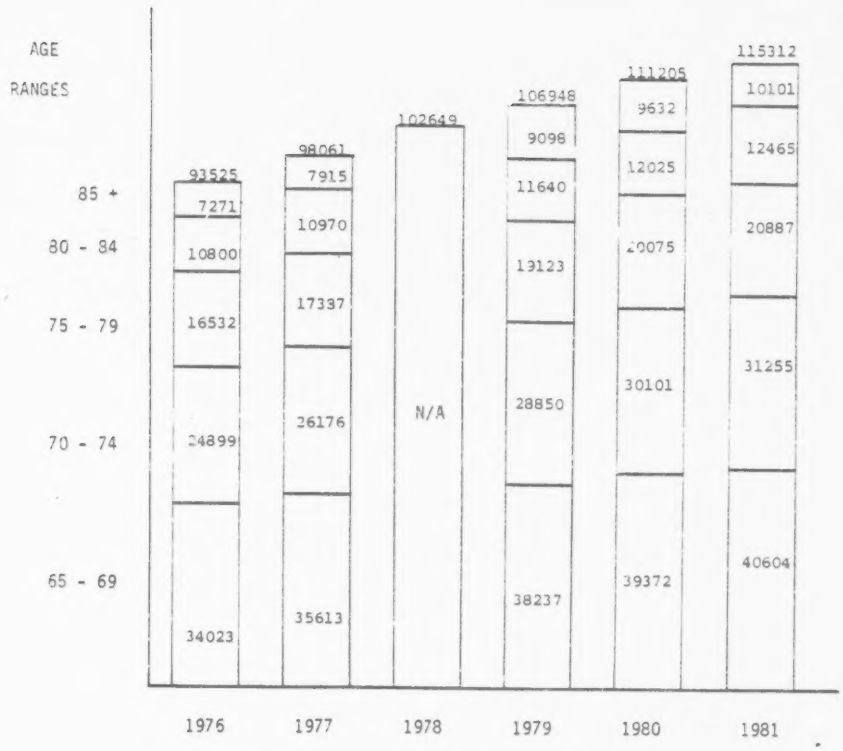
1 AHA National Data Network, Annual Survey of Hospitals, 1980, 1981, 1982 and 2/10/84 telephonic exchange with NMPSRO.

2 Graph 1, 10/12/83 NMPSRO letter, on DHMS/HCFA, OPSRO memorandum 5/20/83.

EXHIBIT I
Page 1 of 4

GRAPH 1

NEW MEXICO MEDICARE ELIGIBLES: 1976 - 1981



SOURCE: 10/12/83 NMPSRO letter, on DHMS/HCFA, OPSRO memorandum 5/20/83.

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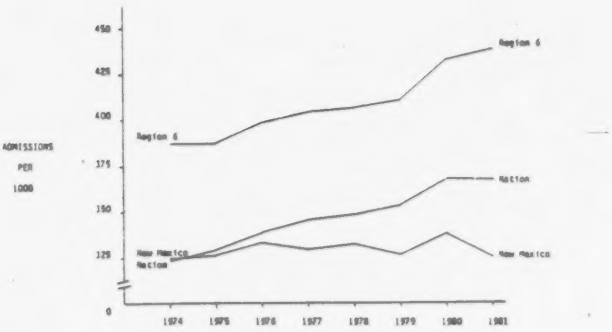
GRAPH 2

NEW MEXICO MEDICARE INPATIENT DATA

MEDICARE ADMISSIONS PER 1000 ELIGIBLES: 1974 - 1981

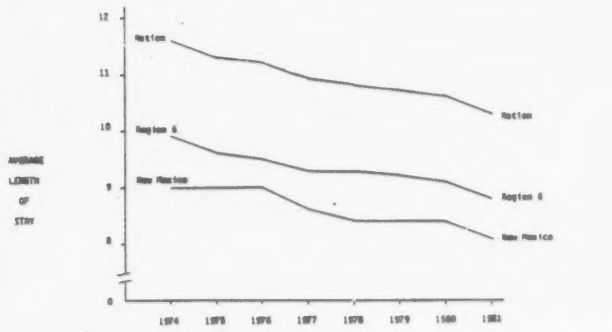


Note: Region 6 includes:

Arkansas
Louisiana
New Mexico
Oklahoma
Texas

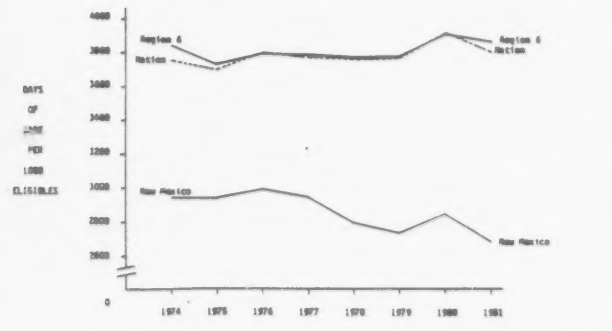
GRAPH 3

MEDICARE AVERAGE LENGTH OF STAY: 1974 - 1981



GRAPH 4

MEDICARE DAYS OF CARE PER 1000 ELIGIBLES: 1974 - 1981



Source: DHHS/HCFA
OPSSO Memorandum
5/20/83

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NEW MEXICO MEDICARE INPATIENT DATA

TABLE A (for Graph 2) MEDICARE ADMISSION RATE PER 1,000 ELIGIBLES
Comparison of New Mexico, Region 6, Nation

Year	New Mexico	Region 6	Nation
1974	325.4	387.5	324.5
1975	326.1	387.3	238.7
1976	333.3	398.7	339.2
1977	329.9	405.8	345.2
1978	332.0	407.0	348.9
1979	326.1	412.7	353.4
1980	337.9	431.3	369.7
1981	325.2	437.7	368.3

TABLE B (for Graph 3) MEDICARE AVERAGE LENGTH OF STAY:
Comparison for New Mexico, Region 6, Nation

Year	New Mexico	Region 6	Nation
1974	9.0	9.9	11.6
1975	9.0	9.6	11.3
1976	9.0	9.5	11.2
1977	8.6	9.3	10.9
1978	8.4	9.3	10.8
1979	8.4	9.2	10.7
1980	8.4	9.1	10.6
1981	8.1	8.8	10.3

TABLE C (for Graph 4) MEDICARE DAYS OF CARE PER 1,000 ELIGIBLES:
Comparison of New Mexico, Region 6, Nation

Year	New Mexico	Region 6	Nation
1974	2,935.9	3,836.0	3,751.7
1975	2,928.5	3,728.1	3,706.3
1976	2,988.3	3,792.2	3,794.5
1977	2,929.1	3,785.5	3,779.3
1978	2,785.3	3,767.7	3,762.4
1979	2,729.4	3,782.4	3,771.7
1980	2,845.5	3,908.0	3,916.4
1981	2,637.1	3,853.0	3,809.8

SOURCE. DHHS/HCFA/OPSRO Memorandum 5/20/83 dsd 6/83

PATIENT REVENUE DATA ON COMMUNITY HOSPITALS
IN NEW MEXICO FOR 1982
1982 UNCOMPENSATED CARE DELIVERED BY NEW MEXICO COMMUNITY HOSPITALS [1]

YEAR	TOTAL NET REVENUE[2]	TOTAL UNCOMP. CARE[3]	AS A % OF TOT. NET. REV.[2]	TOTAL ADMISSIONS mcare / mcaid	CONTRACTUAL[4] ADJUSTMENTS	AS A % OF TOT. UNCOMP. CARE	AS A % OF TOTAL NET REVENUE[2]
1980	$ 297,881,000	57,432,321	19.28%	41501 / 15574	30,336,820	52.82%	10.18%
1981	370,842,973	75,878,198	20.46%	44064 / 16192	39,772,151	52.44%	10.72%
1982	470,351,017	106,295,601	22.60%	45355 / 14488	54,358,244	51.14%	11.56%
TOTAL	$1,139,074,990	239,606,120	21.04% (Average)	130920/ 46254	124,467,215	51.95% (Average)	10.93% (Average)
% Change '80-'81	24.49%	32.12%		6.18% / 3.97%	31.10%		
% Change '81-'82	26.83%	40.09%		2.88% / -10.52%	36.67%		
% Change '80-'82	57.90%	85.08%		9.29% / -6.97%	79.18%		

1 Community hospitals excludes Federal (VA, IHS), State and specialty facilities.

2 This includes all revenue, i.e., patient revenue and other operating revenue, as well as nonoperating revenue (contributions, grants, etc.) Contractual allowances, bad debts, charity and other losses are not included in the figure.

3 Total Uncompensated Care - Amount of billed services for which neither payment nor partial payment was made.

4 Contractual Adjustments - Amounts not paid by Medicare, Medicaid, County Indigent Care, or the Indian Health Service for authorized services provided to such patients.

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1982 UNCOMPENSATED CARE DELIVERED BY NEW MEXICO COMMUNITY HOSPITALS[1]

YEAR	BAD DEBT[5]	AS A % OF TOT. UNCOMP. CARE	AS A % OF TOT. NET REVENUE[2]	CHARITY[6]	AS A % OF TOT. UNCOMP. CARE	AS A % OF TOTAL NET REVENUE[2]
1980	23,980,307	41.75%	8.05%	3,115,194	5.42%	1.05%
1981	26,957,815	35.53%	7.27%	9,148,232	12.06%	2.47%
1982	36,436,461	34.28%	7.75%	15,500,896	14.58%	3.30%
TOTAL	87,374,583	36.47% (Average)	7.67% (Average)	27,764,322	11.59% (Average)	2.44% (Average)
% Increase '80-'81	12.42%			193.66%		
% Increase '80-'81	35.16%			69.44%		
% Increase '80-'82	51.94%			397.59%		

5 Bad Debts - Amounts uncollectable for services rendered to private pay patients.

6 Charity - Care provided to patients who were determined not to be eligible for Medicare, Medicaid, etc., but who were unable to pay. Includes Hill-Burton obligation services rendered.

SOURCE: American Hospital Association
National Data Network
Annual Survey of Hospitals, 1980, 1981 & 1982

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Supplement to Share

MEDICARE PRICE BLENDING ON A DRG-SPECIFIC BASIS

At its meeting January 28, the AHA Board approved prompt exploration of hospital-specific/national average price blending on a DRG-specific basis as the most equitable means of determining the Medicare prices to be paid to each hospital and discussion of this with the Department of Health and Human Services and appropriate congressional committees, with reporting to and discussion by member hospitals. This approach is the same generically as that which has been used to establish DRG prices for hospitals in New Jersey. A further explanation of this approach to price setting is summarized below:

Key Features

1. The current transition approach would be eliminated and replaced with a system that would require that an institution-specific/national average price blend be calculated for each DRG based on the statistical distribution of costs around the DRG's mean cost. In calculating the distribution, costs would be corrected for differences in area wages and indirect teaching expenses.

   Where the distribution is narrow, i.e., patient costs throughout the country for a particular DRG are closely grouped around the mean cost for that DRG, the price paid for that DRG would heavily reflect the national average. Conversely, where the distribution is wide, the price would be heavily weighted toward the hospital-specific rate.

2. An area wage adjustment would continue to be applied to the national component of the price, to correct for labor market differences. The adjustment, however, would be more precise than the current system, accounting for full and part time employment differences, and would use more precise labor market areas, not MSA/non-MSA boundaries.

3. Separate payments for indirect medical education costs would continue to be made to teaching hospitals.

4. Special treatment would continue to be needed for cancer hospitals, referral centers, hospitals serving a disproportionate number of Medicare or low income patients, and sole community providers.*

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*However, to the extent that these types of hospitals serve Medicare patients classified predominantly in DRGs whose cost distributions are widely dispersed, their prices would be heavily weighted toward their hospital-specific rates, thus reducing the need for exceptions or other special treatment.

Prepared by the American Hospital Association

Benefits

- Results in an equitable, evolutionary move to national average DRG pricing.* Where a hospital's Medicare patients are predominatly in DRGs with narrow cost distributions, the hospital will be paid predominantly national average DRG rates.

- Eliminates the need for separate urban and rural rates.

- Eliminates the need for regional rates.

- Eliminates the need for the hospital industry, the Administration and the Congress to revisit equity issues every year.

Medicare Budget Effect

None. No increase in total expenditures.

Allocation of the Medicare budget would be changed to provide better inter-hospital equity.

Logistics

HCFA currently has the data and computer software needed to implement this approach to price blending. The quality of currently collected data, however, must be improved. This latter requirement is necessary even under the current system.

Mechanics

The price paid to each hospital would be a combination of the hospital-specific price/DRG and the national mean price/DRG. The lower the coefficient of variation (See Exhibit 1) the more weight given to the mean price. In contrast, if the coefficient of variation for a specific DRG is 1 or more, the Medicare payment would be based entirely on the hospital-specific price.

The blending weights would be the coefficient of variation factors. However, these weights could be subject to negotiation.

Example

See the Attachment.

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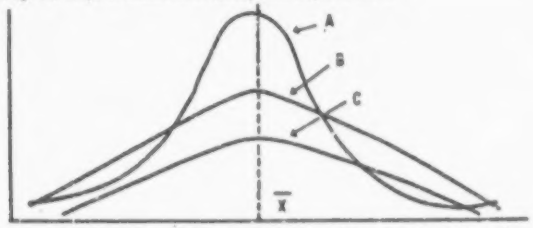
*The individual DRG cost distributions will narrow naturally as hospitals improve their cost performance in response to the incentives, as DRG coding improves, and as the DRG patient classification system itself is refined.

32-906 O—84——6

Exhibit 1
Calculation of a Coefficient of Variation

A coefficient of variation measures dispersion around an average. The larger the coefficient, the greater the dispersion, or the less tightly clustered the observations around the average ($\bar{X}$). Graph A clusters more closely than Graphs B and C.



A coefficient is calculated by dividing the standard deviation for a set of numbers by the average for the set. Suppose that the average cost ($\bar{X}$) of treating eight patients is:

$$\bar{X} = \frac{\Sigma X_i}{N} = \frac{\$1{,}750 + \ldots + \$2{,}372}{8}$$

$$\$1{,}809 = \frac{\$14{,}472}{8}$$

The standard deviation (SD) is obtained as follows:

Cost (X_i)	$(X_i - \bar{X})$	$(X_i - \bar{X})^2$
$1,750	$1,750 − $1,809 = $ − 59	3,481
1,500	1,500 − 1,809 = −309	95,481
1,690	1,690 − 1,809 = −129	16,641
1,000	1,000 − 1,809 = −809	654,481
1,920	1,920 − 1,809 = 111	12,321
2,000	2,000 − 1,809 = 191	36,481
2,250	2,250 − 1,809 = 441	194,481
2,372	2,372 − 1,809 = 563	316,969
$14,472		$1,330,336

$$SD = \sqrt{\frac{\$1{,}330{,}336}{8}}$$

$$SD = \sqrt{\$166{,}292}$$

$$SD = \$407.79$$

If the standard deviation equals $407.79 and the average is $1,809 the coefficient is 0.23. If the standard deviation was $1,100 and the average was $1,809, the coefficient is 0.61.

$$\text{Coefficient of variation} = \frac{SD}{\bar{X}}$$

$$0.23 = \frac{\$407.79}{\$1{,}809} \qquad 0.61 = \frac{\$1{,}100}{\$1{,}809}$$

ATTACHMENT

DRG - Specific Price Blending: A Hypothetical Example

Assumption:

- The hospital-specific rate is $6,000.
- The federal rate (after adjusting for area wages) is $5,500
- The hospital has patients in three DRGs
- The three DRGs are hypothetical, with coefficients of variation (standard variation as a percentage of the mean), cost weights, and admission volumes as shown below. The coefficient of variation determines the institutes-specific/federal price blend percentages (e.g., if the coefficient of variation for a DRG is 0.25, the price blend will be 25% hospital-specific and 75% federal).

Medicare Prospective Pricing and Computations (Assume No Outliers and No Indirect Teaching Payments) under DRG-Specific Price Blending:

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
DRG	Coefficient of Variation	Hospital-Specific Blend	Federal Blend Percentage	Hospital-Specific Rate	Federal Rate	Blended Rate [(2)x(4)]+[(3)x(5)]	Cost Weight	Admissions	Payment [(6)x(7)x(8)]
501	0.25	25%	75%	$6,000	$5,500	$5,625	.8100	2,000	$9,112,500
502	1.00	100	-0-	6,000	5,500	6,000	1.2500	2,000	15,000,000
503	.50	50	50	6,000	5,500	5,750	1.1000	2,000	12,650,000
								Total:	$36,762,500

In contrast, total payments would be the following if the blending percentages were:

	Total Medicare Payments
75% hospital-specific/25% federal for all DRGs	$37,130,000
50% hospital-specific/50% federal for all DRGs	$36,340,000
100% federal for all DRGs	$34,760,000

Chairman DOMENICI. Charles Gonzales, deputy director of New Mexico Health Facilities Association, we are glad to have you here.

STATEMENT OF CHARLES H. GONZALES, EXECUTIVE DIRECTOR, NEW MEXICO HEALTH FACILITIES ASSOCIATION

Mr. GONZALES. Yes, I will. I will start up by saying, Senator Durenberger, I do disagree. I just returned from Washington, D.C., yesterday. It was 70 degrees.

Medicare's DRG-base prospective payment system for hospitals could have a very significant impact on nursing homes as hospitals are encouraged to reduce inpatient lengths of stay in order to maximize profit margins. The scenario has yet to be played out because the medicare prospective payment system will be phased in over 3 years and in this current initial year, not all of the included hospitals have come under the system due to their fiscal accounting year.

HOSPITALS IN LONG-TERM CARE BUSINESS

If the hospital industry becomes aggressive in long-term care through nursing home acquisitions, construction of new facilities, adoption of the swing-bed provision. and so on, the nursing home industry may find itself up against considerable competition for hospital discharge patients. Hospital-based and hospital-affiliated skilled nursing facilities are considerably more expensive than free-standing nursing homes without any empirical evidence of greater quality of care levels.

I will say here that this is not as a result of hospital-based facilities but rather because of the effect of the step-down allocation process resulting from the NCFA 25–52 report.

On the other hand, if hospitals seek out some of the bed capacity of nursing homes to accommodate earlier discharge patients, the long-term care industry might find itself in a very favorable position to increase its market potential for such patients and thus lessen reliance on the medicaid reimbursement system.

Public policymakers will need to be aware of the financial incentives to hospitals under the medicare plan for maximizing patient revenues through excessive or unnecessary admission practices. Elimination of medicare's prior 3-day hospitalization requirement for skilled nursing facility coverage would help mitigate such admission practices for patients who could be treated more appropriately and more economically in a nursing home.

INCREASE NURSING HOME PARTICIPATION IN MEDICARE

Public policymakers will also need to develop a medicare skilled nursing facility prospective payment methodology that encourages increased participation from more of our cost efficient and economically operated nursing homes than is currently the case. At present, very few nursing homes participate in medicare to any significant degree. Approximately 500 long-term care facilities in the United States account for more than 50 percent of the medicare long-term care expenditures. Nursing homes need to be encouraged to participate in medicare as a low-cost, high-quality alternative to expensive inpatient hospital care.

Increased participation by skilled nursing facilities is expected as hospitals are encouraged to reduce patient length of stays and thus seek out lower cost care such as nursing homes. This poses a potential problem in New Mexico in particular, as there are only 369 skilled nursing beds in this State with 228 of those beds concentrated in the Bernalillo County area. That is Albuquerque.

HOSPITAL NURSING HOME CONTRACTUAL ARRANGEMENTS

What kind of arrangements can be made on the prospective payment system? Hospitals can do nothing. They can make informal arrangements with nursing homes to insure bed availability. But, more frankly, we see hospitals that will enter into contractual arrangements with nursing homes. Contracts made take the form of no fee service arrangements which provide the hospital with first priority placement in exchange for exclusive referrals from the hospital; possibly per-bed "bonus" payments to a nursing home for each bed referral accommodated; retainer amounts paid facilities per contractual period to guarantee bed availability, this could be done on an individual bed basis; a block arrangement for a specific amount of beds, a whole wing of a facility, or other contractual variation; cost-plus purchase contract under which hospitals would subcontract with nursing homes to provide services. Payment for such services would be made by the hospital to the nursing home.

Also the hospitals may lease beds or groups of beds. They may develop distinct part options. Hospitals can seek legislation modification to accommodate swing-bed provisions in urban areas. Hospitals could build nursing homes, acquire an existing nursing home, acquire and/or build nursing homes in joint venture arrangements with other hospitals or physician groups.

I would like to emphasize that the comments I am making are conjecture and predictions and the best guesses. We, as the other part, do not have empirical evidence to back up the things that might happen. We feel that these things are probable.

Each of these arrangements are intended to financially benefit a hospital under the prospective payment system by transferring hospital patients to a lower cost provider setting, thus reducing hospital inpatient lengths of stay in order to maximize DRG revenue and profit.

The end result of all of these arrangements and variations of arrangements is the increased predictability of nursing home bed availability for hospitals wishing to maximize inpatient length of stay. These arrangements can be a positive development in overall case management and administrative enhancement for both the medicare program and nursing home operation. As the impact of DRG payments are felt on the hospital financial scene, the incidence of contractual arrangements with nursing homes should increase. Patients being transferred could be private pay, medicare skilled nursing facility entitled, or medicaid potential. Each type of patient and financial source will represent several unique issues.

QUESTION ARISING FROM CONTRACTUAL ARRANGEMENTS

We, and our national government, are currently exploring several questions which have arisen under the contracting issue that

relate to medicare/medicaid reimbursement and coverage requirements. Questions such as: Are such contractual arrangements legal? Are they in conflict with medicare/medicaid public health program policy? Do such payments to the nursing home constitute revenue offsets? And, finally, the question of whether such payments can be construed to be medicaid supplementation and statutorily prohibited under section 1909(d) of the Social Security Act. The precise contractual terms appear to be of critical importance in determining whether any such contractual payments are legal and allowable under medicare and medicaid, including whether such payments could be considered supplementation.

A preliminary review of the issues indicates that if the payments are made without reference to a particular medicaid patient, for example, a flat retainer fee paid on an annual basis to a nursing home to guarantee the bed availability, such payments would not appear to meet the definition of supplementation as promulgated by section 1909(d). Further, it appears that payments construed—and contractually structured—to represent compensation—to a nursing home—for the added risk factor in maintaining the contracted-for bed availability would be permissible. These payments would compensate for the monetary risk a nursing home incurs whenever it guarantees bed availability.

I have additional data available that has been supplied to you in the written document, but I would like to synopsize briefly that there are three additional considerations that DRG's will have significant impact upon and these considerations, of course, have been existing during the pre-DRG period as they are in the post-DRG period.

THE 3-DAY HOSPITALIZATION REQUIREMENT

The first is the prior 3-day hospitalization requirement. Addressed, I believe, by Senator Durenberger and many other agencies, the Financing Administration, the issue is that the prior 3-day rule requires that an individual be placed in the hospital first before coming to the nursing facility, which itself creates improper placement and additional cost to the program.

MANDATE COINSURANCE PERIOD FOR HOSPITALS

We feel that the coinsurance requirement of the period of time should become mandated for hospitals. The time is 61 days, while for a nursing facility it is 21 days. That provides an impetus for the individual to remain in the hospital until the 61st day before being placed in a skilled nursing facility.

PRESCREEN INDIVIDUALS FOR TYPE OF CARE NEEDED

Last, we feel that it is possible for the Health Care Financing Administration or even the State or the National Congress to come up with prescreening mandates for identification of those individuals that are more properly placed in a long-term care facility rather than in an acute-care hospital. We feel that with this kind of prescreening mandate, that the State HMO's have some guid-

ance to help them to determine the proper level of quality of care for individuals seeking out health care.

Again, I would like to thank you for allowing me to represent long-term care in the State of New Mexico to you, Senator Durenberger and Senator Domenici, today.

Chairman DOMENICI. The additional remarks that you have attached to your testimony will be made a part of the record.

[The material referred to by Mr. Gonzales follows:]

MEDICARE COVERAGE OF DIRECT ADMISSIONS TO SKILLED NURSING FACILITIES

Introduction

Currently, SNF Medicare coverage is limited to those patients who have experienced at least a three-day hospital stay prior to admission to the SNF. This requirement and other associated Medicare provisions have introduced financial incentives to use hospital inpatient services in lieu of SNF services and have created barriers to the more cost-effective use of SNF services. The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 addressed the three-day prior hospital stay requirement by permitting the Secretary of Health and Human Services to waive the requirement provided that the change does not alter the nature of the benefit or increase the total payments under Title VIII. (See Appendix A for a further discussion of TEFRA.)

To this point, the Health Care Financing Administration (HCFA) has concluded that available evidence indicates that the Congressionally imposed preconditions for waiving the three-day prior hospital stay cannot be met. The purpose of this paper is to constructively challenge that conclusion by a careful and thoughtful reexamination of the available evidence. Accordingly, this paper is based on an in depth analysis of the issue by Health Policy Alternatives, Inc., which was commissioned by the American Health Care Association.

To encourage the development of a proposal in response to the TEFRA legislation, this paper will discuss three issues. First, it will examine the shortcomings--from the point of view of the task imposed by TEFRA--of past studies of dropping

the three-day prior hospitalization requirement as a condition for SNF nursing home coverage. It will also suggest ways to correct these shortcomings in any future experiments. Second, it will identify barriers the Medicare program has created to making cost effective choices between hospital and SNF nursing home services. Third, it will examine changes in coverage conditions which would permit the choice between hospital and SNF nursing home services to include efficiency considerations.

The Issue

The conclusion drawn by HCFA from the demonstrations and the evaluation of those demonstrations by Abt Associates (see Appendix B) is that there is no evidence to suggest that unnecessary admissions are being made to hospitals for the sole purpose of qualifying the patient for subsequent Medicare SNF coverage. In other words, the examination of the data failed to uncover an unusual frequency of three day hospital stays for Medicare admissions.

The response of the American Health Care Association (AHCA) is three-fold. The first is that the absence of excessive three day hospital stays does not refute the hypothesis that unnecessary hospital admissions are being made. It is likely that, under the prevailing set of circumstances regarding hospital vs. SNF patient cost sharing (see the following section on "Barriers to Cost-Effective Choices") and the inconvenience of transferring a patient from one site to another in the middle of a course of treatment, hospital care was viewed as a substitute for SNF care rather than as a qualification for SNF care. Thus, once an admission was made to a hospital, the patient tended to complete the

course of treatment in the hospital, even when a SNF level of care became appropriate, and even if the initial hospital admission was induced by the three day prior hospital stay requirement. Once in the hospital the patient stayed in the hospital. Since the Abt Study was carried out prior to prospective Medicare DRG reimbursement, it is therefore not surprising that three day hospital stays were not prevalent.

Medicare's prospective DRG-based reimbursement system for hospitals has a very strong incentive for hospitals to continue to admit patients who could be treated appropriately in a SNF in order to gain the full prospective payment for the hospital admission. Furthermore, under Medicare's prospective payment system, hospitals now have an added incentive to reduce inpatient lengths of stay and to discharge these patients to a SNF. This incentive may be strong enough to overcome any remaining barriers to such transfers. To the extent this occurs, SNF costs will be incurred by the Medicare program that are in addition to the full payment to the hospital. That is, Medicare costs are likely to increase above the level attributable to the substitution of hospital services for SNF services alone. Therefore, the second part of the AHCA response to the HCFA conclusion is that data collected after the introduction of the DRG payment system are likely to demonstrate quite strongly that excessive three day hospital stays are being incurred for the dual purpose of qualifying patients for SNF coverage and generating a full admission payment to the hospital.

The third, and most important, part of the threefold AHCA response to the HCFA conclusion, however, is that HCFA has been asking the wrong question. Instead of asking whether the available evidence supports the presence of hospital

admissions (either partially or solely) for the purpose of qualifying for SNF Medicare coverage, HCFA should be examining (1) the extent to which the three day prior hospital stay requirement (and the other barriers to SNF utilization discussed, below) induces the utilization of expensive hospital services as a substitute for the less expensive SNF services, and (2) the magnitude of the costs which could be avoided by removing this requirement (and other barriers).

In summary, then, the response of AHCA to HCFA's conclusion regarding the effect of the three day stay requirement is:

1. Past data showing an absence of excessive three day hospital stays result from strong incentives to substitute hospital care for SNF care throughout the spell of illness.

2. Future data are likely to exhibit excessive three day hospital stays because of the financial incentives that have been introduced by the DRG payment system to admit all SNF level of care patients to hospitals and then to discharge them as quickly as possible to SNFs.

3. The relevant question to be asked is: What are the costs which can be avoided by altering the present incentives to substitute hospital care for SNF care under the Medicare program?

Barriers to Cost-Effective Choices

From the preceding section, it is clear that the three day stay limitation is but one of several restrictions or barriers which together provide strong, positive incentives to initially admit patients to the hospital rather than the SNF (even if the three day prior hospital stay was waived by the Secretary) and to retard the timely transfer of stabilized patients to SNFs (although, with the advent of the DRG payment system, these latter barriers are likely to be overridden by the strong financial incentives the hospital has to discharge Medicare patients to SNFs after an initial hospital stay). Whether operating in the pre-or post-DRG environment, however, these restrictions and barriers tend to work in concert with the three day limitation to induce the application of an inappropriate level of resources (i.e., hospital rather than SNF care) to those patients for which there is a choice. Accordingly, each of these restrictions and barriers is worthy of individual consideration, in many instances separate from the three day limitation issue.

Cost Sharing - Currently, if a patient is admitted directly to a SNF as an alternative to hospital care, he/she is not entitled to Medicare coverage as long as the three day limitation stays in effect. More subtle, but perhaps more important, is the financial advantage of staying in the hospital once admitted compared to transferring to a SNF. Coinsurance for a hospital Medicare stay is not encountered until the 61st day, whereas it is encountered on the 21st day of a SNF stay. Unless the patient is certain that the SNF stay will be less than 21 days, the patient is financially induced to stay in the hospital until the 61st day. A better coordination of hospital

and SNF benefits and a more fair application of the coinsurance provisions would reduce the bias toward continued hospital stays.

DRG - Even if the three day limitation was waived by the Secretary, the present hospital Medicare reimbursement system provides a very strong inducement for hospitals to seek and admit patients who could be equally well served in a SNF. This represents an inefficient use of resources and is exascerbated by the financial incentive the hospital has under Medicare to discharge these excessive admissions as soon as possible to SNFs. In this manner, Medicare not only pays full reimbursement to the hospital for the admission, but it also pays for the subsequent SNF stay. Clearly, we must find some approach to minimize such excess hospital admissions. The existence of the three day limitation only serves as a further justification for such hospital admissions.

M.D. Reimbursement - Physicians have a natural preference for treating their patients in a hospital setting because of the convenience of seeing patients in close proximity. There are also other reimbursement advantages to the physician when the patient is treated in a hospital as opposed to a SNF. Not only are physicians not paid for the extra travel costs incurred when seeing a single patient in a SNF, but the Medicare payment for daily visits to patients in the hospital setting is generally accepted as good medical practice, whereas the Medicare payment for daily visits in SNFs is heavily scrutinized and requiring considerable administrative justification. This barrier to patient transfers to SNFs would present an obstacle to direct admissions to SNFs even in the absence of the three day limitation.

Heavy Care SNF - Since the current Medicare system of paying SNFs does not differentiate adequately among patients according to their cost of care, there is a strong disincentive for SNFs to accept heavy care patients under the Medicare programs. Thus, heavy care patients have the least chance of being transferred to the SNF setting, and, even if the three day limitation were waived, a strong incentive would remain for Medicare heavy care patients to receive hospital care in lieu of SNF care.

Other Factors - Once a patient is admitted to a hospital, there are both medical and social factors which tend to inhibit transfers to SNFs, even when the appropriateness of a SNF level of care is apparent to all. Transfers of patients often involve trauma of both a medical and a social nature, but it is even more unfortunate when such trauma is forced on a patient by an inappropriate initial placement in a hospital.

Suggested Solutions

Clearly, some of the barriers described above suggest their own solutions which are worthy of consideration. But, there are other, important steps which should be undertaken, in concert with the dropping of the three day prior hospitalization requirement, that would serve to more rationally utilize SNF and hospital resources and ease the strain on the financially pinched Medicare trust funds. These steps take these basic forms:

1. Provide nationwide medical profiles of the types of Medicare patients whose characteristics indicate they may be equally well treated in a nursing home as in a hospital.

2. Provide for a patient screening system to determine whether hospital or nursing home services would be more appropriate.

3. Provide for an initial deductible for a direct admission to a nursing home and make the level of coinsurance essentially comparable between the two types of institutions. Also, provide for a coordination of the coinsurance requirements between hospitals and SNF stays for those patients who are transferred.

Medical Profiles - SNF utilization standards or criteria for appropriateness by statute and regulation, are preferable to leaving the matter solely to the discretion of PROs or to the screening committees of individual institutions. Basically, patients who do not require continuous access to physician care would normally be the only ones eligible for coverage of their direct SNF admissions (an exception to this rule may be possible in the case of some hospital-based SNFs or certain other SNFs if a special qualification program were established for purposes of granting such exceptions).

The Department of Health and Human Services could easily identify the types of cases where the patient's condition and service needs could generally be assumed to be handled appropriately in a SNF without prior hospitali-

zation. The Department could prepare, add to, and modify such a list of categories as it gained experience. The initial list should be relatively brief to assure than no significant cost risk was being assumed. Data from the channeling studies now underway should be helpful in establishing such a list. Candidates for the list include:

- o beneficiaries needing skilled nursing for a terminal illness;
- o beneficiaries receiving Medicare home health services who develop an acute illness that requires nursing attendance of such a duration that care of that illness at home is not cost-effective;
- o beneficiaries in ICFs, where the services are not covered by Medicare, who develop acute illness that requires skilled services; and
- o beneficiaries still in the "spell of illness" initiated by previous hospital care who require readmission for further skilled attention.

Some of the services that SNFs may render as an alternative to hospitalization include not only generalized skilled nursing, but rehabilitation, intravenous therapy, and the monitoring of vital signs and patient intake and output.

Patient Screening - It is important that the screening--triage--be conducted before the hospital admission so that the patient can be assigned to the most appropriate setting. This screening would be quick and easy for persons

requiring surgery or other treatment available only in hospitals, and would need to be conducted with care only for other patients. Preadmission screening should, in any case, be a matter of increasing concern under the hospital prospective DRG reimbursement system in order to avoid unnecessary increases in admissions. The PRO/intermediary should take into account the possibility of the SNF alternative where hospital admissions rates appear unusually high, and should exert pressure for its use. Pressure is likely to be feasible, however, only if Medicare coverage is available for the direct admission of patients to SNFs.

Since the PRO program, unlike PSRO's, will not be required to seek prior approval for the conduct of a screening program for Medicare patients referred for hospitalization, it is likely that most PRO's will require preadmission certification for elective hospital admissions. These programs would be aided by the development of national standards or criteria for determining the appropriate level of care (as described, above), and used, for example, to permit the three-day requirement to be waived where the admission to a SNF followed a decision, based on standards or criteria acceptable to Secretary, that the SNF care was an acceptable alternative to hospital care.

One could also create the appropriate climate for patient screening by providing compensation to a hospital for its efforts in screening and referring patients to SNFs for direct admission. The cost of such a modest incentive for hospital referral would be more than offset by the reduced cost in services provided.

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Prior screening of hospital admissions is the key to effective placement. Implementation of such a program will require the refinement of assessment mechanisms and the dedication of the resources necessary to support the review program. The opportunity to move ahead with this effort in concert with the new PRO program should not be remissed.

Patient Cost Sharing - Should the three day stay requirement be waived, it would be appropriate that an initial deductible be provided for direct admissions to SNF. This deductible should equal the average cost of one or two days of SNF care. Transfers from the hospital should not have to pay the SNF deductible, having already paid the hospital deductible.

Coordination of hospital and SNF benefits would also improve if the copayment for both hospital stays and direct admissions to SNF commenced after 60 days (actually other coverage periods would be acceptable as well, as long as the period for SNFs was the same as the period for hospitals). In the case of transfers from hospitals to SNFS, the SNF deductible would be avoided but the hospital days of stay should be counted along with the SNF days of stay to determine the beginning date of the SNF copayment. (For example, a transfer to a SNF after a 30 day hospital stay would receive only 30 days of SNF care before copayment was required.)

The level of SNF coinsurance should either be reduced proportionate to the level for inpatient hospital services or determined without reference to the inpatient hospital deductible. Making the SNF coinsurance amount

more comparable to that for hospital inpatient services would remove some of the adversity from the patient/physician decision making process.

Summary

There seems to be no question that many patients can be treated appropriately in either a hospital or a SNF. Even though SNF treatment is less costly, present Medicare provisions provide counter-productive inducements to use hospitals in preference to SNFs. There are a number of steps that can be taken to reduce this counter-productive bias without increasing Medicare or federal budget costs. The adoption of these steps would constitute an approprite response to the direction provided by the TEFRA legislation.

APPENDIX A

Legislative Background to the Medicare SNF Prior Hospital Stay Requirement[1]

Section 123 of the Tax Equity and Fiscal Responsibility Act of 1982, (TEFRA) directs the Secretary of Health and Human Services to provide, under certain circumstances, coverage of extended care services under Medicare which are not preceded by a hospital stay. The pertinent provisions are contained in a new Subsection 1812(f) of the Social Security Act which reads as follows:

"(f)(1) The Secretary shall provide for coverage . . . of extended care services which are not post-hospital extended care services at such time and for so long as the Secretary determines and under such terms and conditions (described in paragraph (2)) as the Secretary finds appropriate, that the inclusion of such services will not result in any increase in the total of payments made under this Title and will not alter the acute care nature of the (extended care) benefit . . .

"(2) The Secretary may provide —

"(A) for such limitations on the scope and extent of (non-post-hospital extended care) services . . . and on the categories of individuals who may be eligible to receive such services, and

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[1]Prepared for the American Health Care Association by Health Policy Alternatives, Inc.

"(B) notwithstanding Sections 1814, 1861(v), and 1886, for such restrictions and alternatives on the amounts and methods of payment for services described in such subsection, as may be necessary to carry out paragraph (1)."

These provisions, by empowering the Secretary to broaden the coverage of extended care, provide for wide Secretary discretion with regard to:

- the time the coverage would begin and when and whether it should be terminated;
- limitations to be imposed on the scope and extent of services that are covered;
- limitations on the types of patients whose services may be covered; and
- special provisions affecting both the amount and method of payment for the services.

The Secretary must find that the new services will neither increase total payments under Medicare nor change the acute care nature of extended care benefits before the special authorities given to the Secretary may be used. The conditions applied in determining when and to what extent payment should be made were apparently intended by Congress to be tools for targeting the new coverage largely to patients who would otherwise have received other covered services. These conditions, together with limits on amounts of payment, were intended to provide assurance that the additional cost of the new services would be balanced by savings on expenditures that would have been made on other covered services. Of course, the primary method of maintaining this budget neutrality would be by reducing the use of hospital services, since hospital services are considerably more costly than nursing facility services on a day for day basis.

APPENDIX B

Studies and Demonstration Projects Relating to the Medicare SNF Prior Hospital Stay Requirement[1]

The Health Care Financing Administration (HCFA) has sponsored several studies and two demonstration projects related to the general issue of the effects of eliminating the three-day prior hospitalization requirement for coverage of extended care; and has commissioned an evaluation of these projects by Abt Associates, Inc. Neither the demonstrations nor the outside evaluation, however, tested the effect of targeting devices that would focus added services on areas where cost reduction were most promising.

In other words, the demonstrations merely provided data on what occurred when the three-day requirement was dropped, with no new requirements of any kind being added. No reports have thus far been issued by HCFA of any investigation by staff of the targeting issue. In fact, comments made by HCFA staff one year ago, focused on the degree to which hospitalization occurred when the motivation was to gain eligibility for Medicare coverage of extended care. As Patrice Feinstein put this point during a congressional hearing:

> "Our actuaries found that there is no evidence that any significant number of beneficiaries are admitted to hospitals solely to meet the prior stay requirement for skilled nursing facility

[1]Prepared for the American Health Care Association by Health Policy Alternatives, Inc.

benefits. Thus, the actuaries found that there would be no decrease in hospital utilization to offset the increase in skilled nursing facility utilization." (An increase that was expected to follow if the three-day stay requirement were discarded.)

This HCFA concept of the cost issue -- whether hospital admissions occur in order to gain eligibility for nursing facility care -- is repeated in much of the Abt Associates evaluation report, but the Abt report also makes a different assumption than HCFA about the motivations that underly hospitalization. The Abt report comments at its outset "although expenditures for skilled nursing care are only a small share of the total Medicare budget, Medicare patients sometimes enter the hospital and incur expensive stays solely to meet entry requirements for the Medicare Part A skilled nursing benefit."

The difference in conclusions between the HCFA actuaries and Abt Associates as to whether there is any significance to the number of entries to hospitals to establish eligibility for extended care is not the key issue, however, in any case. Of greater importance, in our opinion, is a different question: What patients now admitted to hospitals might have been admitted instead to skilled nursing facilities and might have been treated just as well but at lesser cost? This question was not dealt with in the course of the demonstrations and received little attention in the evaluation. It also was not mentioned in the Feinstein statement. We believe it is the crucial question in regard

to implementing Section 123 of TEFRA. The Abt evaluation report does include the following relevant statement, however:

> ". . . physician practice patterns and reimbursement incentives lead physicians to care for their patients (in) a hospital rather than a nursing home setting. Moreover, interviews with hospital staff suggest that they do not perceive it to be their role to refer patients to SNF's prior to hospital entry. Nor are there financial incentives or effective preadmission review procedures for hospitals to triage patients who are more appropriate for SNF care. Although PSRO's in both states were aware of the demonstrations, they did not make any special effort to route patients to take advantage of the direct entry SNF option. It appears that there are gray areas of patient conditions that are routinely treated both by hospitals and SNF's." (Emphasis added.)

This evaluation report comment suggests the model which should be employed in considering the implementation of Section 123. The concept should be one of hospitals competing with SNF's on the basis of their cost effectiveness in treating the group of patients for whom admission to either would be medically appropriate. In other words patients would be treated at the site where the treatment is most cost effective, whether the care involves the initial admission or a subsequent transfer from one site to another. Under present circumstances patients may be admitted to hospitals as a substitute for extended care rather

than to qualify for such care. If this is the case, the data will show "no evidence that any significant number . . . are admitted to hospitals solely to meet the prior stay requirement" as HCFA pointed out, because the hospital stays substituted completely for the SNF stays.

Since the demonstrations and the evaluation were not intended to and therefore, in effect, failed to consider the competition possibility, they contribute little to furthering its development. Despite this and other shortcomings which result in an understatement of the achievable savings (e.g., failure to allow for Medicaid reductions when Medicare coverage expands), the study material suggests that it may be possible to develop a strategy of substituting other requirements for the three-day stay requirements and to thereby yield a cost saving to the federal government if the three-day stay condition were, in appropriate circumstances, omitted. The major point is that present law provides a counter-productive incentive in favor of admission to the higher cost hospital for treatment that is covered by Medicare as opposed to a less costly skilled nursing home. The limitations on coverage that should be examined should deal with patients who, if provided skilled nursing facility care, would not need to be admitted to hospitals.

The studies do suggest some of the kinds of cases which may fall into what Abt Associates call the "gray area." These include patients in the terminal stage illness as well as patients -- like cancer cases --for whom curative treatment effort no longer seems beneficial, but whose expected life span may be of some duration; patients in need of rehabilitation after a fracture, amputation, or stroke; and patients who require intravenous therapy, respiratory therapy,

intake and output monitoring, or similar services which at least some nursing facilities could render adequately.

While the demonstrations and analysis were not designed to permit a comparison in hospitalization rate between persons in any one of these categories who do and do not have the advantage of coverage of extended care without the requirement of a previous stay in a hospital, the evaluation report implies that a difference in that rate occurred during the demonstrations. Such a difference would undoubtedly increase if the Medicare program established unbiased rules for choice of site of care and provided for increased effort to screen patients for their potential for adequate treatment in a SNF rather than a hospital.

As reported in the Massachusetts experience, almost all direct admission nursing home stays that were covered -- about seven in eight direct admission cases -- seemed to be initiated by a nursing home. The patient was referred by the same or another home or by a facility that operated a nursing facility in conjunction with a hospital. Most cases in Oregon were similarly initiated. There are no adequate screening or other administrative processes in Medicare to make referrals in a way that provides a significant measure of assurance that the more cost-effective site for care will be chosen. Indeed the incentive for the physician and patients in this "gray area" is to refer to the hospital, since there is no threat of denial of claim when a patient is hospitalized, even though adequate, lower cost treatment in a nursing home may have been possible. The frequency of occurrence of some of the types of cases mentioned ("gray area" cases) as having potential for cost-saving direct admissions are as follows:

	Percent of SNF Patients[1]	
	Massachusetts Demonstration	Oregon Demonstration
Expired	19.4	29.5
Cancer Diagnosis	9.5	17.7
Cerebrovascular Accident	12.8	14.9
Fractures	18.4	2/
Amputation	7.5	2/

The difference between Massachusetts and Oregon with regard to fracture and amputation cases may be related to the larger participation in the Massachusetts demonstration of rehabilitation hospital-skilled nursing combination facilities. In such facilities screening of patients to determine which site is more appropriate is much more likely to occur than in rehabilitation hospitals with no connection to a skilled nursing facility. It is not clear how similar rehabilitation patients were treated in Oregon or whether hospital rehabilitation was more frequent in the Oregon demonstration than in Massachusetts. Nor are data available on the total cases with such diagnoses in either state and on the distribution of those provided rehabilitation services between hospitals and SNF's.

The large percentage of patients who expired in the nursing facility during the demonstration also occurs in the case of extended care provided after hospitalization under existing coverage rules. In 1976, some 31.6 percent of Medicare

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1/ Patients may be counted in both the expired category and a diagnostic category.

2/ Not among the five most frequently occurring diagnoses.

SNF patients expired during their covered stays. At the same time, the average length of extended care stay among covered direct admissions was 23 days in Oregon and 26 days in Massachusetts. This admission duration was much briefer than the combination of hospital and extended care in normal Medicare experience in 1976, when the hospital stay alone averaged 25 days and the subsequent covered nursing facility stay lasted an average of 24 days. Of course at least part of the difference in duration may have flowed from differences in patient mix.

Two other HCFA-sponsored investigations also bear on the issue of the potential for cost saving through the substitution of nursing facility care for hospital services. Gertman and Restuccia point out that previous studies indicated that inappropriate use of hospital days generally exceeded 10 percent. Using their own criteria in one hospital, they found one in four days to be inappropriate, and about 10 percent of admissions to be inappropriate. Inappropriate days occurred in almost 30 percent of stays. The effect of the three-day stay requirement may, of course, be one of the factors inducing extra stays, but may also increase inappropriate hospital days in an appropriate stay. These days may include more than the second or third days in the stay. Once present for three days, when there is clearly a financial advantage to the patient for hospitalization compared with SNF services, the hospital stay may continue for one or more additional days if the further need for care is brief and the trouble of transfer is not considered worth suffering for the small cost difference involved, for Medicare. There is no financial advantage to the patient or hospital to shift to a SNF unless denial of the hospital claim is a threat.

The Gertman-Restuccia protocol for assessing appropriateness of a day provides interesting evidence of the nature of the present administration of Medicare's test of the "reasonableness" of a hospital service in determining coverage and the inadequacy of this coverage test for assuring use of the more cost-effective type of institution. The tests applied in the protocol that justify hospitalization on a day fall into two categories:

- the provision of "services that would usually only be provided at an acute hospital level of care;" or

- a patient condition that was so unstable that immediate availability of acute hospital services was required even if not provided on a day.

The first of these categories may be adequate for presuming that a hospital day was covered, but does not assure that only the hospital (not an SNF) could have provided the service, and therefore it is not a test of maximum cost effectiveness. It deems that a hospital day was "appropriate" even if a skilled nursing facility was available that could have provided the service adequately and the service in such a facility would have been less expensive. If these two conditions are satisfied, program costs could be reduced without disadvantage to the patient. The point is that a different test than that used by Certman-Restuccia should be used if the issue is whether the hospital or the SNF should be used when both types of facilities can provide a service. Care in both would be "appropriate" in a sense and would apparently be covered by Medicare under

present rules, but one would be a more cost effective choice and that one should be encouraged.

The Gertman-Restuccia paper provides some further details useful ire; and has commissioned an evaluation of these projects by Abt Associates, Inc. Neither the demonstrations nor the outside evaluation, however, tested the effect of targeting devices that would focus added services on areas where cost reduction were most promising.

In other words, the demonstrations merely provided data on what occurred when the three-day requirement was dropped, with no new requirements of any kind being added. No reports have thus far been issued by HCFA of any investigation by stiled observation and recording of these fluid measurements." The point is that some nursing homes are, in fact, capable of performing the service adequately at lower cost and are more appropriate choices than a hospital. Similarly, the protocol criteria include assumptions of hospital stay appropriateness in the following other instances:

- o any test requiring strict dietary control, for the duration of the diet;

- o respiratory-intermittent or continuous respirator use and/or inhalation therapy (with chest PT, IPPB) at least thrice daily;

- o parenteral therapy-intermittent or continuous IV fluid with any supplementation (electrolytes, protein, medications);

- o continuous vital sign monitoring -- at least every 30 minutes, for at least 4 hours;

- o intramuscular and/or subcutaneous injections at least twice daily;

- o close medical monitoring by nurse at least three times daily, under doctor's orders; and

- o fever at least 101 rectally (at least 100 orally), if patient was admitted for reasons other than fever.

In cases covered by all these criteria, there is a clear possibility that at least some (and in some states, all) SNF's would have performed adequately. There are indeed, published reports of frequent performance of intravenous feeding at the patient's home and informal conversations with personnel of the Delmarva Foundation for Medical Care and Kaiser-Permanente confirm this point. Monitoring may or may not require hospitalization, depending upon whether the patient is so unstable that certain findings during monitoring would indicate the need for immediate use of facilities available only in hospital or immediate physician attention which can be presumed to be available without delay at any time in most hospitals. Fever may or may not justify continuing hospitalization rather than transfer to a SNF depending on the patient's condition and the etiology of the fever.

The Borchardt article describes an application of the Gertman-Restuccia protocol. That article indicates the protocol was used to develop profiles

which "helped identify significant variations in nonacute utilization from physician to physician, and has greatly reduced such (inappropriate) utilization in member hospitals." The Borchardt paper thus suggests a technique for inducing more cost-effective use of hospitals and SNF's through sampling surveys of use by physicians and pointing out to them instances where a comparatively high ratio of inappropriate days occurred.

The Delmarva Foundation which Mr. Borchardt directs, also tightened up somewhat on the Gertman criteria to limit the degree to which cases in some of the categories listed above would be deemed to be appropriately hospitalized, for IV therapy, for example.

A Public Health Service sponsored study by Hurtado, Greenlick, and Seward of home care and skilled nursing care by the Kaiser Foundation health plan had as one of its purposes to determine their cost and to evaluate their impact on hospital use, but the study of SNF use consisted of post-hospital care so that it is only partially relevant to the current issue (although patient screening to determine appropriate patient placement is required in any event). One of the findings of the Kaiser project is that "it is imperative that within such an integrated system there be no financial incentive for the patient or the physician to use one kind of medical care -- either acute hospital, extended-care facility or home care -- when it is otherwise inappropriate...(and)...barriers to admission to the extended-care facility and home care should be kept to a minimum to encourage appropriate use." The possibility of an unbiased choice between hospital and SNF services clearly came to their mind over ten years ago.

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Chairman DOMENICI. Dr. Ottensmeyer, we are delighted to have you.

STATEMENT OF DAVID J. OTTENSMEYER, M.D., LOVELACE MEDICAL CENTER, ALBUQUERQUE, N. MEX.

Dr. OTTENSMEYER. Thank you very much. It is a privilege for all of us to have you here in New Mexico and the opportunity to talk with you about these difficult problems that you are wrestling with, and we are, too.

I am David Ottensmeyer, and I am a physician and a neurosurgeon. My practice and organizational experience have been in large group practices of medicine at the Marshfield Clinic in Wisconsin and at the Lovelace Medical Center here in Albuquerque. I have been the chief executive officer of the Lovelace Medical Foundation during the past 7½ years.

I am also the current president of the American Group Practice Association, which is a trade association of group practices of medicine, including most of the large group practices throughout the country, among those the Mayo Clinic and the Park-Nicollet Clinic, and the Duluth Clinic, all of which you recognize, Senator Durenberger.

The Lovelace Medical Foundation is a nonprofit organization in New Mexico, which has headquarters here in Albuquerque. It includes a hospital licensed for 235 beds of acute medical/surgical care, a skilled nursing facility of 90 beds, a multispecialty group of 125 physicians, and 2 major research institutions.

We operate a health maintenance organization that has 43,000 participants currently. The remainder of our revenue, about two-thirds of our reimbursement, is under a fee-for system, including about 30 percent of it in the medicare arena. We are also a major teaching affiliate of the University of New Mexico School of Medicine. The foundation operates health care facilities in six locations here in Albuquerque, and two locations elsewhere in the State of New Mexico. We have about 1,500 employees, 300 of which are involved in research and 1,200 are involved in health care.

It appears to me that the prospective reimbursement system is the heart of changes that are driving the reform of the medicare and medicaid system, and that this can only be labeled a health care revolution. For us in health care, I have little doubt that it will inject price sensitivity into health care. People in our institution and elsewhere in the health care business in Albuquerque are now busy pursuing strategies to maximize efficiency by an attempt to identify costs and control them. We understand the concept of redirection of health care dollars to efficient providers.

HOSPITAL COLLECTIONS UP UNDER NEW PLAN

Now I would summarize the concerns that we have about the DRG's system in the written testimony that I presented to you. We agree fundamentally with the things that Mr. Howard Shaver presented from the standpoint of the hospital association. For your information, we have been under the DRG system since the first of October of last year. I think we had the privilege of being just about the first, if not the second, in the State to go under the

system. In reviewing our experience over the first quarter, we find that our reimbursement rate is perhaps as high as 6 percent higher than it was under the preceding system when we could wash out the effects of the graded implementation of the system that is occurring.

PHYSICIAN PEER REVIEW NOT NEW

As we look at the basis for that change, there are two things that I think we can identify. I think that as an integrated health care organization with a group practice associated with it, peer review, of the type of thing you were talking about earlier with Dr. Jordon, is a way of life in a group practice of medicine and always has been. We don't have to make a whole lot of changes and we know who the expensive physicians are in our organization, and we have great motivation to do something about it.

And this brings me to the second point that I think may be favorably impacting us. Our physicians have a vested interest in being certain that the financial performance of our institution is good. If the hospital does not perform well, that has an immediate bottom line effect on what happens to the physicians. And I think it is a combination of these factors that we have been able to identify at this point that probably is favorable for us. And it is the type of thing that all large group practices of medicines are looking at, as doctor organizations throughout this country today, that while we don't like the rate of change and we don't like to deal with the new any more than anyone else, we feel that doctor organizations are in a particularly good posture to deal with those changes.

PROSPECTIVE PAYMENT SYSTEM PROBLEM FOR PHYSICIANS

Now, moving on to the next phase of implementation of the DRG's in out-of-hospital settings and for physicians, we at Lovelace, quite naturally, have additional thoughts, since Lovelace is a doctor organization that grew out of a group practice of medicine.

Once physician services are brought into a prospective payment system, some new and difficult political and administrative problems will erupt. Contrary to the situation in the hospital, in which a global fee is conceivable, in a single organizational entity, the typical practice style of American physicians is not amenable to that organizational reality. By and large there is no organization.

A major portion of the medical practice by physicians in this country is carried on by individual or partnership combinations of physicians in small independent practices, if you will. In any one particular case, of a patient with a health problem, an informal alliance of several physicians might come together to address that problem. This is a temporary ad hoc team. There generally is not a single organizational entity underlying that team which is capable of sorting out the cost involved, much less allocating the global fee available under the DRG system.

Notwithstanding those facts, there is a distinct logic for consideration of transference of the global fee—which is the concept of the DRG, of course—into the hands of the medical profession. The great debate about health care that is going on in our society today

has to do with allocation of health resources. The person that allocates the health care resources is the physician.

As all you know, direct or indirect decisions of the physician accounts for over 70 percent of the expenditures that are made for health care by patients, or in behalf of patients. This simple fact is the source of a great anxiety of all of us who run hospitals today. When I put on my hospital CEO hat, I realize that cost-effective decisions in patient management are usually out of the control or the domain of the hospital and out of the domain of the practicing physician.

HEALTH MAINTENANCE ORGANIZATIONS

The payment of a global fee for the management of an individual episode of disease for a medicare client could be facilitated if it were directed to an organization that encompassed all of the facilities, equipment, and personnel, including physicians necessary for the diagnosis and treatment of that individual patient.

That, you will note, implies an organization, and examples of such organizations include the emerging preferred provider organizations, the now well-known Health Maintenance Organization, and the increasing number of larger multispecialty medical groups. This, actually, is the core of the HMO approach to cost reduction, of course.

It is now well established that group model and staff model HMO's can effect reduction of health care costs. For those of you who are interested in the medicare cost reduction problem, it will be instructive for you to look at the experience of a group model HMO, such as the Fallon Clinic in Massachusetts, which is effectively and dramatically accomplishing that end in behalf of medicare patients in that State.

COMPETITION IN THE MEDICAL WORLD

Finally, I wish to comment upon the so-called competition approach to the control of health care costs. Let me first say that, contrary to popular concept, competition is not new to the health care business. The medical profession is as backbiting as any, and I recall a hospital administrator I once knew who always moved the sunshade on his car to block out the view of his competitor's hospital when he drove by.

But the competition was different in the past and rarely included the concept of competition which you now envision, which is price competition. Most of us here in Albuquerque believe that neomedical competition, if you will, is upon us and we are working hard to adapt to it. We believe we can adapt, although there may be some casualties in the process and we must presume that such is the implicit objection of society, as expressed in policy initiatives from the Federal level, which we have seen so dramatically expressed in the last year and a half.

PHYSICIAN INPUT IN REGULATORY PROCESS

I certainly urge caution as you move forward with new initiatives. It would be very helpful if the regulatory process, such as

publication of regulations on the medicare prepaid program, were more prompt and offered better opportunity for input by those of us who must live with those regulations in the future.

In my view, the medical profession and the physician should be given good cause and motivation to move squarely into the center of the management of the process of allocating health care resources. For the medical profession, this means moving away from the classical protectionist and reactionary positions of the American Medical Association.

For the health care organizations, this means putting physicians in top levels of management and decisionmaking. For society, and I think you, the decisionmakers, it is an opportunity to create systems that will motivate physicians to do creative hands-on management in this process of revolution that is going on in health care. Whatever the new initiatives may be on your agenda, I think you would be well advised to constantly keep in mind the economic value of exchanging our current focus on sickness for a new vision of health promotion and wellness.

Do not hesitate to build factors which will motivate that on the part of both the consumer and the health care provider in that direction. I greatly appreciate the opportunity to address you this morning.

Chairman DOMENICI. Thank you very much, Doctor.

[Dr. Ottensmeyer's full prepared statement follows:]

STATEMENT OF DAVID J. OTTENSMEYER, M.D. BEFORE HEARINGS OF SENATORS DOMENICI AND DURENBERGER- February 15, 1984.

Senator Domenici, Senator Durenberger, Members of the Panel:

It is a privilege for all of us to have you here in New Mexico to talk about the difficult issues facing you in government and us in health care relative to financing medical services.

I am Dr. David J. Ottensmeyer. I am a physician and a neurosurgeon. My practice and organizational experience have been in large group practices of medicine at the Marshfield Clinic in Wisconsin and at the Lovelace Medical Center here in Albuquerque. I have been the Chief Executive Officer of the Lovelace Medical Foundation in Albuquerque during the past seven and one-half years. I am also the current President of the American Group Practice Association, which is a trade association of group practices of medicine, including most of the large group practices throughout the Country, such as the Mayo Clinic, the Park-Nicollet Clinic, and the Duluth Clinic, all of which you, Senator Durenberger, recognize.

The Lovelace Medical Foundation is a non-profit organization in New Mexico, headquartered in Albuquerque. It includes a hospital licensed for 235 beds of acute medical/surgical care, a skilled nursing facility of 90 beds, a multi-specialty medical group of 125 physicians, and two major research institutions.

We operate a health maintenance organization that has 43,000 participants, and we are a major teaching affiliate of the University of New Mexico School of Medicine. The Foundation operates health care facilities in six locations here in Albuquerque, and two locations elsewhere in New Mexico. We have 1,500 employees, of which 300 are involved in research, and 1,200 are involved in health care delivery services.

As we understand your inquiry today, you are particularly interested in our current thoughts about Medicare and Medicaid reform, as well as DRG's and the prospect of an expanded use of DRG's as a payment mechanism to fund out of hospital health care services, including physician care in the future.

It appears to me that prospective reimbursement is the heart of changes in Medicare reimbursement and it is the driving force in what can only be labelled a health care revolution. I have little doubt that it will inject price sensitivity into health care. People in our institution and elsewhere in the health care business in Albuquerque are now busy pursuing strategies to maximise efficiency by an attempt to identify and control costs. We understand the concept of re-direction of health care dollars to efficient providers.

Notwithstanding these realizations, we have great concern about what is occurring for a variety of reasons. Prospective reimbursement is based upon the accounting concept of standard costs. Unfortunately, there is no such thing as a standard

patient, a standard doctor, a standard hospital, or a standard form of pathology. It is certainly possible to describe statistically a mean, or average patient, doctor, or pathologic condition. However, the statistical concept of the mean, as you know, is not a reality. There is virtually never an average anything.

All of this leaves us in health care with the problem of creating those average concepts which drive patients and health care practices toward a mean value. We are concerned that this process can be reduced for economic or competitive reasons to the process of the lowest common denominator.

We are also concerned that the immediate focus on cost effectiveness of patient care, using standard or average cost, has not been fully tested. Established DRG's are based upon cost collected after the fact. We are not aware that they were tested for validity; certainly not here in New Mexico. These DRG global fees are not the costs of keeping the patient well, nor do they constitute new approaches to health care delivery. By design, DRG's minimize or ignore technology, medical education, and indigent care considerations. While they will drive costs to an "appropriate level", we are not certain that the level will "appropriately" address the health care needs of our community.

Moving on to the next phases of implementation of DRG's in out of hospital settings and for physicians, we at Lovelace, quite naturally, have additional thoughts since Lovelace is a doctor organization that grew out of a group practice of medicine.

Once physician services are brought into a prospective payment system, some new and difficult political and administrative problems will erupt. Contrary to the situation in the hospital, in which a global fee is conceivable, in a single organizational entity, the typical practice style of American physicians is not amenable to that organizational reality. A major portion of medical practice by physicians in this Country is carried on by individual or partnership combinations of physicians in small independent businesses, if you will. In any one particular case, of a patient with a health problem, an informal alliance of several physicians might come together to address the problem. This is a temporary ad hoc team. There generally is not a single organizational entity underlying that team which is capable of sorting out the cost involved much less allocating the global fee available under the given DRG. Notwithstanding those facts, there is a distinct logic for consideration of transference of the global fee (which is the concept of the DRG) into the hands of the medical profession. The great debate about health care that is

going on in our society today has to do with allocation of resources. The person that allocates the health care dollar resource is the physician. As all of you know, direct or indirect decisions of the physician accounts for over 70% of the expenditures that are made for health care by patients, or in behalf of patients. This simple fact is the source of a great anxiety of those of us who run hospitals today, who realize that cost effective decisions in patient management are usually out of our control and are the domain of the practicing physician. The payment of a global fee for the management of an individual episode of disease for a Medicare client could be facilitated if it were directed to an organization that encompassed all of the facilities, equipment and personnel, including physicians, necessary for the diagnosis and treatment of that individual patient. That, you will note, implies an organization and examples of such organizations include the emerging Preferred Provider Organizations, the now well known Health Maintenance Organization, and the increasing number of larger multi-specialty medical groups. This, actually, is the core of the HMO approach to cost reduction. It is now well established that group model and staff model HMO's can effect reduction of health care costs. For those of you who are interested in the Medicare cost reduction problem, it will be instructive for you

to look at the experience of group model HMO's such as the Fallon Clinic in Massachusetts, which is effectively and dramatically accomplishing that end in behalf of their Medicare patients.

Finally, I wish to comment upon the so called "competition approach" to control of health care costs. Let me first say that, contrary to popular concept, competition is not new in the health care business. The medical profession is as back-biting as any, and I recall a hospital administrator I once knew who always moved the sunshade on his car to block out the view of his competitor's hospital when driving by. But, the competition was different in the past, and rarely included the concept of competition which you now envision, which is price competition. Most of us here in Albuquerque believe that neo-medical "competition" is upon us and we are working hard to adapt to it. We believe we can adapt, although there may be some casualties in the process and we must presume that such is the implicit objective of society, as expressed in policy initiatives from the Federal level, which we have seen so dramatically expressed in the last year and a half. I certainly urge caution as you move forward with new initiatives. It would be very helpful if the regulatory process, such as publication of regulations on the Medicare prepaid program, were more prompt

and offered better opportunity for input by those of us who must live with those regulations in the future.

It is time that economic decisions, obviously necessary on the part of the federal government, be separated from political decisions. It appears we are moving toward some process that will curtail the level of available health care services in America; certainly below the level those of us in health care envisioned 10 years ago. By any other name, that probably means rationing of health care services just as so many other Western societies have been forced to do. There needs to be an explicit political decision on that and it needs to be articulated by policy makers and decision makers, rather than those of us who are the vendors of health care. In my view, the medical profession and the physician should be given good cause and motivation to move squarely into the center of the management of the process of allocating health care resources. For the medical profession, this means moving away from the classical protectionist and reactionary positions of the American Medical Association. For health care organizations, this means putting physicians into top levels of management and decision making; for society and you, the decision makers, it is an opportunity to create systems that will motivate physicians to do creative, hands on management in this process of revolution that is going on in health care.

Whatever the new initiatives may be on your agenda, I think you would be well advised to constantly keep in your mind the potential economic value of exchanging our current focus on sickness for a new vision of health promotion and wellness. Do not hesitate to build factors which will motivate that on the part of both the consumer and the provider of health care services.

I greatly appreciate the opportunity to address this panel on these critical issues. Thank you very much.

Senator DURENBERGER. Let me start by just expressing my appreciation to all three of you. I told Pete here a little while ago that the accumulative effect of all six witnesses has led me to the conclusion that there is something special about New Mexico, because in all my travels, I haven't had quite this degree of insight, not only into the problem but into the solution, from all the witnesses here this morning. I will just start out by saying that I appreciate that.

Obviously, one of our problems in dealing with the issues that the three of you presented us with here is, I believe, that the global approach that you suggested in your testimony, and I suggested in my opening statement, is the way we ought to go.

What I need to hear, I guess, from all three of you, is, what are some of the serious problems that we are going to face as we go from here to there? Pete, a little while ago, about an hour or so, was on this business of, out of $100 billion, one-half billion might derail the train. In the last couple days of exploring the effects of competition and choice, it is clear to me that it is what we do or don't do about indigent care, what we do or don't do about long-permanent care, what we do or don't do about teaching, what we do or don't do about the Stormy Joneses of this world. She is the record setter, and she has got a hired analyst that we are all paying for.

ONE DRG TO COVER ALL

One of the issues is: Do you have to deal with those current cross-subsidies in the system first before you get to your global payment or can you sort of run them side by side? I suppose the second part of it is, and this sort of gets to the doctors, as I said, to the AMA, and other people, when we pass out our money for your global or your prospective, we have to give it to somebody.

I don't know if AHCA is still at that point, but some folks want one DRG for the hospital, another one for the doctors, another one for the nursing homes. I have said it once and I will continue to say it as often as I can. "No way, Jose," or however you may put it in New Mexico. One payment, at least, or maybe some modifications with options. I get my health care by choosing a doctor. I don't call up the hospital or the nursing home or something like

that and say, "Hey, I got an ache or a pain" or something like that. I call my folk's doctor. I inherited my folk's doctor just like I inherited their lawyer and things like that. The doctor makes all those decisions.

I am concerned that there aren't enough of you out there today so that if we move too quickly to some kind of a large global payment, we move that out into America, which is the same concern I have on the voucher, there are a whole lot of physicians that are not ready for it, who may at some time, or could, take this whole system down in the process.

Having said those two things, and having indicated my basic agreement with what I have heard from all three of you, we are concerned about substitution. Pete is concerned about substitution of service and so am I. Rather than turn it over to HCFA or add a new home health plan or new hospice plan, I would just as soon turn it over to an expert to help me make any decision on substitution. But what are the big problems that lie out there for us in making this decision?

Mr. SHAVER. First, I think we have got to get some experience with the hospital. Because I don't think any of us know what has been done to the system. Now, I am not sure how long we need to have that experience, but once we get some experience with that, and that is simpler than this global thing, I would tend to agree with you on that—and this isn't necessarily an official position of anybody but me talking—that there is going to have to be one payment to somebody or something. It would strike me that it would be unwise to have that be the same somebody in every place and in every circumstance.

Try some multiples of that, some options of an organization that we may not even know of right now, that would be the body to take the money and to divvy it out. Try it with the hospital base, try it with this sort of organization that Dr. Ottensmeyer operates, and there may be some other things. It would strike me that a multiple approach would be some way to try it and maybe some experiments, using just two or three places that have very different kinds of circumstances, and seeing how those function. That is just an off-the-top-of-my-head point of view.

SYSTEM NEEDED FOR LONG-TERM CARE FACILITIES

Mr. GONZALES. I believe that the largest problem of the national medicare problem in long-term care right now is utilization of the program, as I indicated to you. Only 500 long-term care facilities represent 50 percent of the facilities utilized in New Mexico. Those statistics could be even worse. Only 369 beds total, 228 of those are in the Albuquerque area, and only 40 percent of those being utilized. There is definitely something wrong with our participation in the medicare program. We, too, feel, like American Health Care Associations, that it has to be implemented on a piecemeal basis, that is the hospital DRG system and then eventually a system for long-term care facilities.

There is talk now of the resource utilization groups that perhaps will coattail the diagnosis related groups. We feel that something has to be done. In New Mexico there has been a tremendous cost

shift as a result of this inequity to the State program, the medicaid program. Now, we as an industry are between the rock and the hard place; the State telling us we have got to shift back to the Federal Government programs and the Federal Government giving us the kind of incentives to push back to the State programs.

In the meantime, the recipient, like the industry, I suppose, is caught between the rock and the hard place. We have provided in New Mexico for ICF waivers. We do have a number of individuals throughout the State who are receiving adequate care in long-term care facilities whose nursing ratios are running in the 2.8 to 3 nursing-hours-to-patient per day. This is way above most States in our region and certainly above national averages, just because our participation in the medicare program is so poor.

LONG-TERM CARE FACILITIES NEEDED IN NEW MEXICO

We have had an adequate proliferation of nursing facilities in New Mexico. I am sure Senator Domenici has been out on a couple of cases of the opening of such facilities in his district. We have very fine facilities. Nevertheless, we need to start looking now at providing some incentive for the long-term care facilities in the State of New Mexico to participate in the medicare program.

Senator DURENBERGER. If I were running a hospital under the DRG system, I guess I would want to buy a service from some free-standing facility that could probably do it a lot better than I could in my expensive beds. But in most States the supply and demand problem, plus the mandates and that sort of thing, that you haven't even got an adequate supply of nursing facilities there because so many States have capped, or apparently must have capped, the availability of those kinds of facilities.

Mr. GONZALES. May I make one last comment? Howard touched on the fact that the growth in the 65-and-older population has been 64 percent from 1970 to 1980. I can also add that the growth of the over-75 population has grown some 78 percent in the State of New Mexico.

NO ORGANIZATION FOR GLOBAL FEE PLAN

Dr. OTTENSMEYER. In responding to the question you asked, Senator, let us start out with the assumption that there will be a global fee, and I think the problem in implementing that is an organizational one. The problem is there aren't organizations there to do it, and to facilitate it. And the main reason really comes down to the medical profession, which is still a fragmented cottage industry, and by and large a Ma and Pa type of business. And ultimately nobody is going to be able to do it, in my opinion, until that issue is dealt with. Now, I don't think that issue will be dealt with unless the Government continues in the direction they are going, and forces the industry to do this.

We are a very conservative profession, and we have fought very, very hard to maintain the status quo in this country for 200 years. But I think we are also enormously capable of change. And if you were out in California, I think you were aware of an enormous background noise which is really doctors and hospitals running around getting ready, trying to reorganize into organizations and

they call them PPO's and call them all kinds of things. But we are perfectly capable of changing. And I think that our economic systems are capable of adapting to it.

MODEL ORGANIZATIONAL EXAMPLES

And there are models already. I referenced the rapid, really frenetic, change that is occurring in California, because somebody rushed them even further than you are pushing us at the present time on a nationwide basis. There are HMO's, and that is a model of a health care system in which all the elements have been brought into one structure. And there are group practices. And the hospitals throughout this country are more and more looking with trepidation but with interest in how they can approach group practices and somehow rationalize the organizational problem.

And there are the new organizations that you may not have heard of, the OWA, which is "Other Weird Arrangements," which I am sure they will occur, too.

MEDICARE OUTLAYS REDUCED

Chairman DOMENICI. Let me ask Howard this. In my opening remarks I indicated that the growth in medicare outlays has been reduced substantially over the last, I guess, 18 months. Is there anything happening in your hospitals in New Mexico that would explain this reduction, this decline?

Mr. SHAVER. I think there has been a lot of things done. One happens to be in the area of productivity. One hospital reported to us just recently that they had a 9-percent increase in productivity in their hospital. They have looked at their staffing, made decisions about both support staff, direct staff, as well as administrative staff in looking at the need for those people to be around, without endangering the patient care.

There has been a lot more done in the area and this has been ongoing for a while, but I think more emphasis in the area of staffing-to-patient levels and acuity level, to assure that the staffing is right, so that one day you may have 30 patients on a unit and need a certain kind of staffing and 2 days later you still may have 30 patients, not the same patients but the patient conditions change and you change the staffing to meet the patients' needs. That is part of it.

Some other things have been the greater conglomeration of purchasing power. In the past a lot of that was done for reusable items, supplies. Much more is going into purchasing CAT scanners, for example, when they are needed; a bunch of hospitals going together and negotiating much better rates for that. There are a number of factors there. Then the other factor, of course, is looking at the need for care, necessity for lab tests, X-ray tests, and those kinds of things. A lot of effort has gone on, on the part of medical staff working with their hospitals, of removing requirements for certain standard tests and those kinds of things. There are a number of factors, plus inflation itself has slowed down.

HOW TO HANDLE INDIGENT CARE

Chairman DOMENICI. I am going to ask all three of you this, and maybe you are the only one that has an answer, but perhaps all three of you could talk a bit about it. You have given us the statistics about indigent care in New Mexico; the fact that we have a very high proportion of uninsureds, no coverage. You told us the numbers on an Albuquerque basis of how much that indigent care is worth and you have told us to be worried about it. But you haven't given us any suggestions as to how we ought to handle it.

INCLUDE INDIGENTS IN MEDICAID PROGRAM

Mr. SHAVER. One situation that we think makes sense here in New Mexico is have a category of a medicaid program so that people must be eligible for aid to families with dependent children or supplemental income to get some medicaid here in New Mexico. We believe in a medically indigent program that would allow that working father and the family to stay together, like the unemployed person right now that isn't covered under our medicaid program, to have coverage.

Chairman DOMENICI. So we will understand that on the record, that means that the national program of the 50-percent match envisions an option as you just described? However, New Mexico has elected to draw a line and not take that one because it also costs New Mexico.

Mr. SHAVER. Yes. That is correct, Senator, except the maximum now in New Mexico is a richer maximum because of our low income.

Chairman DOMENICI. Whatever the maximum.

Mr. SHAVER. So the State would pay 30 percent. Yes, New Mexico has chosen not to go into this program. So some counties have gone with indigent funds. But those are not adequate to meet the needs of those people. So we believe that it is better to spread that amongst everybody. I would just as soon help that person than when I got into the hospital and pay a 22-percent premium, in effect, for taking care of those kinds of people.

Senator DURENBERGER. What would you rather do?

Mr. SHAVER. I would rather pay some taxes when I am well rather than pay an additional 22-percent premium when I am unfortunate enough to have to be admitted to the hospital. And I hope the press doesn't take that wrong, "unfortunate enough to be admitted to the hospital." I would like all of us not to be admitted to hospitals. There went my job.

SPREAD INDIGENT LOAD AMONG HOSPITALS

Senator DURENBERGER. Yesterday I was flying in through the Howood Pass in a helicopter and we were headed for the North Ridge Hospital. The pilot said, "There is the hospital dead ahead." That is not the right word.

Mr. SHAVER. But we think there may be a way of dealing with it and spreading that load amongst everybody. It does not get rid of that problem, but it also guards against some of the concerns that we have had with no certificate of need in this State, of the oppor-

tunity for people and facilities to pick off the good paying patients. This would remove that burden from falling on individual hospitals that may be tax supported, or whatever, and spread out that load burden.

Chairman DOMENICI. In any event, that will certainly get you off that 22 percent that we are at. But there will be some left over everywhere, whatever system, there will be an indigent population coming into your facilities. And with reference to that, it would appear to me that this system that we are pushing will not spread that evenly, but rather the competition will concentrate on avoiding it, I would think. I mean that sounds like business. What would you offer to take that for? What could you do about that?

Mr. SHAVER. One means may be for the medicare system to recognize that as a cost of doing business. And another option may be consideration—and this would be probably at the State level—but consideration as a condition of being licensed that the facilities are required to take their fair share of this. And defining what their fair share is would be difficult. But conceptually, as utility companies take on some business that they prefer not to for doing business as a trade-off, that might be a reasonable option.

Chairman DOMENICI. Dr. Ottensmeyer.

MEDICARE NOT WILLING TO TAKE INDIGENTS

Dr. OTTENSMEYER. It seems to me like ultimately the system, whatever we have, has got to recognize that there will be a cost of taking care of these people. And the problem that we have with the current funding policy of the medicare system is that it is really not ready to step up to the table and pay its part of it. If you accept that there is no free lunch, I think that you also have to look at the fact that as change occurs, if the system is nothing more than business as usual, then somebody is going to fall through the crack, just as I think people are falling through the crack right out in Arizona right now, as they try to force feed a solution to this medicaid problem.

FUNDAMENTAL CHANGES KEY TO PROBLEM

Now, I think the health care business is in the very same position as a lot of other businesses in this country; banking, trucking, airlines and the like, they are being forced to do business in a new way. And I guess it is called deregulation. But it will not be effective if we think that all we are going to do is ratchet down the same process that we have done. I think you are going to have to force the health care industry to make fundamental changes in the way they do business. And the reason that Southwest Airlines is doing well, while Continental Airlines and some others are going broke, is they had a concept of doing something differently.

If you can force those changes on to the health care industry, and whether it be prospective reimbursement or whether it be transferring the financial risk to the shoulders of the provider, that is what you have got to look at. I think you have to introduce HMO's into the medicare and the medicaid system, and you have got to force the people that are providing that service to redesign the system they have got to use the alternative health care provid-

er system. They have got to use alternative providers and they have got to redesign the system.

You just can't build a Continental Airlines to serve cheaper food, you have got to build a Southwest Airlines that does it entirely different.

Chairman DOMENICI. I think the analogy goes about 90 percent, but I think the deregulation, in comparing trucking and airlines, there may be 10 percent where the analogy falls apart, but I think you made a very good point. Did you want to add something?

Mr. GONZALES. Just rapidly. I, too, somewhat agree that the medical needy program is imperative in the State of New Mexico. There are now a tremendous number of people that fall through the cracks, and with any system there will always be people that fall through the cracks. The other item that has not been mentioned in dealing with the elderly is the coordination and education of community support systems. We have worked very hard with agencies that are municipally supported or community supported to help them educate the elderly of our State and to help educate the elderly ourselves as to access and the cost of a long-term care stay.

MEDICAID 70–30 MATCH IN NEW MEXICO

Chairman DOMENICI. Thank you very much. One last question. I saw the dean here. He is our host for lunch. He must be getting hungry. He is walking back and forth. We will be with you shortly. Who has the numbers that we can get on this issue that you raised here about expanding the medicaid coverage election of the State which would trigger 70 percent Federal match?

Mr. SHAVER. Senator, currently in the legislature there is a bill asking the State Human Services Department to study this, because there has not been extensive study on this for consideration in the 1985 session of the legislature. So, to answer your question, the good hard data isn't there yet on how the system would function. It will be.

Chairman DOMENICI. Let me just make a prediction here. That portion is so large, compared to the rest of the country, that this episode we are going through, of transition that you have described here, Doctor, we are going to have more fallout and casualties than the other States, so we are going to have the trauma of people running around saying, "It isn't working. Look what's happening to this hospital and that one," and we may get sympathy and empathy nationally. We usually get help, but we aren't going to get help when they say, "20 percent of your problem you could fix yourself." So we have got to get this one out and get some people that are knowledgeable and understand the delivery system, and what $107 million in New Mexico means in terms of the present base that is paid for by someone. That probably is a very nice piece of change percentwise; isn't it?

Mr. SHAVER. Yes; it is.

Chairman DOMENICI. Do you have a percentage?

Mr. SHAVER. Uncompensated care is almost 23 percent of hospital revenue and I think that is for 1982. My feeling is 1983 is a higher percentage.

Chairman DOMENICI. All right. Do you have anything else? Thank you very much.

[Whereupon, at 12:30 p.m., the committee was recessed, to reconvene at 2 p.m., this same day.]

AFTERNOON SESSION

Senator DURENBERGER. The hearing will come to order.

This afternoon's hearing will start with the panel on the impact on payers for health care. We are pleased to have Donald Sacco, senior vice president, Blue Cross/Blue Shield of New Mexico, and Fred Hannah, GTE Communications System.

As the chairman has said, your full statements will be made part of the hearing record, and you may abbreviate or whatever you please, just so you stay within 10 minutes.

STATEMENT OF DONALD P. SACCO, SENIOR VICE-PRESIDENT, BLUE CROSS AND BLUE SHIELD OF NEW MEXICO

Mr. SACCO. I am Donald P. Sacco, senior vice-president of Blue Cross and Blue Shield of New Mexico. We are pleased to have this opportunity to share our views on the impact of changes in the financing of health care services. In particular, I would like to describe a new program for hospital reimbursement soon to be implemented by Blue Cross and Blue Shield in this State.

The problem of providing quality health services to all citizens at an affordable price is not new. This issue was specifically identified by the 1929 Commission on the cost of medical care. Back then the emphasis was as much an adequate supply of hospitals and doctors as it was financial access. Beginning in the 1930's, this country has committed ever growing resources, both public and private, to the health care field.

We have achieved our national commitment to develop the finest health care system in the world. While there are still Americans who must be brought into the system, we have also generally achieved financial access. But the cost has been enormous. The Nation's 1983 health care bill approximates $350 billion. We are now at the point of asking critical questions about how much more we can afford.

Indeed, the recent changes to medicare reimbursement for hospital services signal the end of an era. Cost-based reimbursement encouraged increased expenditures. In fact, the way the program worked, there were no incentives to hold down costs. During this same time, the public grew to expect, and even demand, that health care be provided without regard to costs.

BLUE CROSS DEVELOPS PROSPECTIVE PAYMENT PLAN

For years, Blue Cross and Blue Shield of New Mexico has paid hospitals on the basis of their billed charges. This, too, is an open-ended payment system and, as in cost reimbursement used by medicare, it did not contain incentives for cost effectiveness. In 1983, our board of directors reviewed spiraling health care costs and the resultant impact on premiums. The board instructed staff to develop a prospective system for hospital reimbursement. And, I would add, one that is sensitive to the needs of New Mexicans. By doing

so, we felt that the combined effect of changes to medicare and Blue Cross payment systems would have a salutary impact on New Mexico's cost increases.

Most prospective payment methods under discussion around the country are similar to medicare's diagnosis related group program, or the DRG program. Under that system, hospitals are paid the same amount for defined types of care. We have selected a different form of prospective payment.

PLAN GEARED TO RURAL AREAS

The Blue Cross and Blue Shield payment system, which we called Reward, recognizes that hospitals have made past decisions about the types of services they make available in their communities. Moreover, in a rural State such as ours, each community tends to be somewhat unique. Under the Reward program, target rates are set in advance for each hospital. These targets are based on the institution's prior average billed charge per admission.

However, we have established limits on the rate of increase to hospital charges for admission. By taking this approach, we have recognized that hospitals cannot undo overnight the years of disincentives that they have had for operations. The hospital which lives within its target is basically unaffected by the system. It has achieved growth but within reasonable constraints. The hospital which exceeds its rate must return that amount by which it is over, to Blue Cross. In turn, this will be credited to our subscribers.

The program is called Reward because as we set each year's new targets, we will carry forward a portion of the savings for the institutions which have actual charges lower than the target rates. This is a fundamental change to the old cost system in which the more you save the lower your reimbursement was. The program has components which recognize changes in the complexity of care that may occur from year to year. It also protects Blue Cross subscribers from institutional charges which are clearly excessive when compared with peer norms. A more complete description of this program has been attached for the record.

The prospective payment system we have developed contains similar incentives to medicare's DRG program. They both encourage cost-effective utilization of hospital services. We have taken many months to design our program. During this process we have communicated with administrators throughout the State. At this time we are inviting hospitals and physicians to join us in an effort to bring the cost of health care under control here in New Mexico, and we look forward to their participation.

REFORMS MUST EFFECT CHANGES IN SERVICE

Senators, you have asked for testimony regarding the impact of payment changes. Medicare's DRG system has not yet been implemented in most New Mexico hospitals. The Blue Cross program will begin soon. Thus we cannot evaluate the impact. We can say, however, that the hospitals and physicians have been actively preparing for prospective payment. And I think this statement reinforces what was heard this morning.

In doing so, there appears to be a moderation in institutional budgets for 1984. Thus we believe that prospective payment programs such as ours can have an impact that can lead to certain savings. These come as a result of efficiency in the operation of institutions. More significantly, they come as a result of changes to utilization patterns.

Reforms, however, cannot take place without affecting services. There will be pressures to reduce hospital stays on a nationwide basis. Given the variation in average length of stay and admission rates, there is much to be accomplished. Physicians will be asked to be more conservative in the diagnostic and therapeutic services that they order for inpatients. Practice patterns will be reviewed through the use of normative data, more intensive than ever before.

As this evolves, there will be some who argue that quality of care is being jeopardized. The health system may also see expansion in the number and types of providers, all with claims of cost effectiveness. Many have to be evaluated to be validated. At the same time, there is likely to be increased regionalization of high technology services. Lastly, consumers will feel the effects as well. There will be less tolerance for the use of discretionary services, particularly at the institutional setting. Consumers will see that physicians will make decisions on the type, amount and place of service for medical reasons and not patient or physician convenience.

PLAN WILL NOT SOLVE COST PROBLEM

I believe that prospective payment will moderate the rate of growth in health expenditures. It is a necessary reform. It forces efficiency for the sake of economic survival. It will also cause some change in the way services are delivered. However, prospective payment, even when extended to other providers such as physicians and nursing homes, is not likely to resolve our cost problems over the long run.

Many factors place inflationary pressure on the system. Expensive technology often used to sustain life is but one. This technology is in the form of mega-dollar therapies such as intensive care used at the beginning and end of life. It is also in the form of very costly investigational surgery such as heart, lung, and liver transplants.

As an aside, Senator Durenberger referenced the little girl who just recently received both a heart and liver transplant.

Rightly, we expect the continuation of scientific breakthroughs which alter the course of life-threatening illness and injury. But there are cost factors to be considered. The end stage renal disease program, ESRD, is an example of the cost potential that we face. In the early 1970's, as the Nation debated whether or not to add end stage renal disease to medicare, the estimates indicated it would be less than $1 million a year as an expense to the medicare program. As you know, we are talking of expenditures of over $2 billion for that program alone. This could pale in comparison to potential costs as we perfect organ transplant procedures and other high technology procedures.

In raising this issue, I offer no judgment or criticism on the merits of technology. Ultimately, this is a public policy issue, as are those related to financial access, how to fund the system and the like, and they will be debated widely, as you both know. In the meantime, prospective payment programs will afford some relief as the Nation faces some of the most difficult questions ever to be encountered when it comes to the health of its citizens.

On behalf of Blue Cross and Blue Shield of New Mexico, I thank you for this opportunity to express these views.

[Mr. Sacco's full prepared statement follows:]

Medicare Reform - National and New Mexico Impact

Statement of

Blue Cross and Blue Shield of New Mexico

before the

Committee On The Budget
United States Senate

Presented by:

Donald P. Sacco
Senior Vice President

Albuquerque, New Mexico

February 15, 1984

Mr. Chairman, I am Donald P. Sacco, Senior Vice President for Blue Cross and Blue Shield of New Mexico. We are pleased to have this opportunity to share our views on the impact of changes in the financing of health care services. In particular, I would like to describe a new program for hospital reimbursement hospital soon to be implemented by Blue Cross and Blue Shield in this state.

Our views have been developed through our long standing experience in the New Mexico health industry. We provide health care benefits to over 200,000 residents and will spend about $130 million on their behalf this year. We have been the Medicare Intermediary since the inception of the program. In this capacity, we serve approximately 138,000 of the State's elderly residents and expect to reimburse health care providers $225 million during 1984. Recently, we have been named the Intermediary for the fifty Indian Health Services hospitals throughout the nation.

The problem of providing quality health care services to all citizens at an affordable price is not new. In fact, this issue was specifically identified by the 1929 Commission On the Cost of Medical Care. Back then, the emphasis was as much an adequate supply of hospitals and doctors as it was financial access. Beginning in the 1930's, this country has committed ever growing resources, both public and private, to the health care field.

We have seen the development of the Blue Cross and Blue Shield non-profit health care plans, begun in the 30's, which today cover over 83 million Americans. The Federal Government has spent millions of dollars to increase health manpower, particularly nurses and physicians. Employers and unions, through bargaining agreements, have negotiated access to health care as part of compensation packages. All levels of government provide health services directly to millions of Americans each year. Finally, we have guaranteed financial access to millions of elderly and poor citizens since the mid-1960's,

We have achieved our national commitment to develop the finest health care system in the world. While there are still Americans who must be brought into the system, we have also generally achieved financial access. But, the cost has been enormous. The nation's 1983 Health care bill approximates $350 billion. We are now at the point of asking critical questions about how much more we can afford. Indeed, the recent changes to Medicare reimbursement for hospital services signal the end of an era. Cost based reimbursement encouraged increasing expenditures. In fact, the way the program worked, there were no incentives to hold down costs. During this same time, the public grew to expect, and demand, that health care be provided without regard to costs.

Prospective reimbursement has provided incentives for cost consciousness. The new method of payment is leading to increased

dialogue between hospital administrators and medical staffs. The discussions center on ways to achieve cost efficiency and still maintain the high standards of quality that we all have grown to expect. Reduction in utilization is the common denominator in these discussions. Therein lies a fundamental change in philosophy. More care is no longer viewed as necessarily better care.

For years, Blue Cross and Blue Shield of New Mexico has paid hospitals on the basis of their billed charges. This is an open ended payment system and, as in cost reimbursement used by Medicare, it did not contain incentives for cost control. In 1983, our Board of Directors reviewed spiraling health care costs and the resultant impact on Blue Cross and Blue Shield premiums. The board instructed staff to develop a prospective system for hospital reimbursement. By doing so, we felt that the combined affect of changes to Medicare and Blue Cross payment system would have a salutary impact on New Mexico's cost increases.

Most prospective payment methods under discussion around the country are similar to Medicare's Diagnosis Related Group (DRG) program. Under that system, hospitals are paid the same amount for defined types of care. We have selected a different form of prospective reimbursement.

The Blue Cross and Blue Shield payment system, called REWARD, recognizes that hospitals have made past decisions about the type

of services they make available in their communities. Moreover, in a rural state such as ours, each community tends to be somewhat unique. Under the REWARD program, target rates are set in advance for each hospital. These targets are based on the institution's prior, average billed charge per admission. However, we have established limits on the rate of increase to hospital charges. By taking this approach, we have recognized that hospitals cannot undo overnight what has taken years to create. We cannot expect instantaneous change. The hospital which lives within its target rate is basically unaffected by the system. It has achieved growth, but within reasonable constraints. The hospital which exceeds its rate must return the amount, by which it is over, to Blue Cross. In turn, this will be credited to our subscribers.

The program is called REWARD because as we set each year's new targets, we will carry forward a portion of the savings for the institutions which have actual charges lower than the target rates. The program has components which recognize changes in the complexity of care that may occur from year to year. It also protects Blue Cross subscribers from institutional charges which are clearly excessive when compared to peer norms. A more complete description of the REWARD Program is provided as Appendix A.

The prospective payment system we have developed contains similar incentives to Medicare's DRG program. They both encourage cost effective utilization of hospital services. We have taken

many months to design our program. During this process, we have communicated with administrators throughout the State. We invite hospitals and physicians to join us in an effort to bring the cost of health care under control here in New Mexico, and we look forward to their participation.

Senator Domenici, you have asked for testimony regarding the impact of the payment changes. Medicare's DRG system has not yet been implemented in most New Mexico hospitals. The Blue Cross program will begin soon. Thus, we cannot evaluate the affect. We can say that hospitals and physicians have been actively preparing for prospective payment. In doing so, there appears to be a moderation in institutional budgets for 1984. Thus, we believe that prospective payment programs, such as ours, can have an impact. They can lead to certain savings. These come as a result in efficiencies in the operation of institutions. More significantly, they come as a result of changes to utilization patters.

Reforms cannot take place without affecting services. There will be pressures to reduce hospital stays. Given the variation in average length of stay and admission rates across the nation, much can be accomplished. Physicians will be asked to be more conservative in the diagnostic and therapeutic services they order. Practice patterns will be reviewed through the use of normative data. As this evolves, there will be some who argue that quality of care is being jeopardized. The health care system may also see expansion in the number and types of

providers, all with claims of cost effectiveness. At the same time, there is likely to be increased regionalization of high technology services. Lastly, consumers will feel the affects. There will be less tolerance for use of "marginal" services, particularly institutional care. Consumers will see that physicians will make decisions on the type, amount and place of service for medical reasons and not patient convenience.

I believe that prospective payment will moderate the rate of growth in health expenditures. It is a necessary reform. It forces efficiency for the sake of economic survival. It will also cause some change in the way services are delivered. However, prospective payment, even when extended to other providers, such as physicians and nursing homes, is not likely to resolve our cost problems over the long run.

Many factors place inflationary pressure on the system. Expensive technology, often used to sustain life, is but one. This technology is in the form of mega-dollar therapies such as intensive care used at the beginning and end of life. It is also in the form of very costly, investigational surgery such as heart, lung and liver transplants. Rightly, we expect the continuation of scientific breakthroughs which alter the course of life threatening illness and injury. But, there are cost factors to be considered.

The End Stage Renal Disease (ESRD) program is an example of the cost potential. In the early seventies when ESRD was added to

Medicare, it was estimated to cost less than one million dollars per year. In 1982, actual costs were about two billion dollars. This could pale in comparison to potential costs as we perfect organ transplant procedures.

In raising this issue, I offer no judgement or criticism on the merits of technology. Ultimately, this is a public policy issue that will be debated widely. In the mean time, prospective payment programs will afford some relief as the nation faces some of the most difficult questions ever to be encountered when it comes to the health of its citizens.

On behalf of Blue Cross and Blue Shield of New Mexico, I thank you for this opportunity to express these views. I would be pleased to respond to questions.

APPENDIX A

Blue Cross and Blue Shield of New Mexico

Prospective Reimbursement

BLUE CROSS PROSPECTIVE PAYMENT FOR HOSPITALS AN INTRODUCTION TO THE REWARD PROGRAM

BACKGROUND

Cost has become the dominant health care issue of the 80's. Historically, the cost of care in New Mexico has been less than that in the nation as a whole. However, during the past few years the rate of increase in this state has been greater than the national average. Consequently, New Mexico is no longer immune to the cost pressures being experienced throughout the rest of the country.

The reasons for the increase in health care costs are many and complex. One major flaw frequently cited is the lack of incentives in the way in which providers are reimbursed. New Mexico Blue Cross and Blue Shield reimbursement to hospitals has been on the basis of uncontrolled billed charges, one of the methods that provides little or no incentive for cost efficiency. If anything, this method encourages escalating prices and/or costs.

Effective March 1, 1984, New Mexico Blue Cross and Blue Shield will implement a new payment program for hospitals, called REWARD. The program will feature a prospective method of payment, covering inpatient hospital services only. The program will apply to New Mexico community hospitals with 100 or more Blue Cross admissions per year.

PROGRAM DESCRIPTION

The primary objective of the REWARD program is to encourage hospitals to control the rate of increase in their average billed charges per admission. This is accomplished through the use of prospective target rates, described as follows.

Prospective Target Rates

At the beginning of the first year, Blue Cross will compute each hospital's average billed charge per admission for Blue Cross subscribers for the prior year. It will then multiply this amount by an inflator, called a price adjustment index, to reflect changes that are expected to occur in the prices of goods and services purchased by hospitals. The result is the hospital's prospective target rate representing the maximum average billed charge per admission that Blue Cross will recognize for payment purposes.

Throughout the year, Blue Cross will continue to reimburse hospitals on the basis of 100% of billed charges, except for outliers which are discussed below. At the end of the year, it will compare each hospital's average billed charge per admission to its prospective target

rate. If the average billed charge is less than or equal to the target rate, no further action will be taken. The hospital will have been paid 100% of its billed charges. If the average billed charge is greater than the target rate, the hospital will need to pay back the difference, times the number of admissions, to Blue Cross.

At the beginning of the second and each subsequent year, Blue Cross will take the lower of each hospital's average billed charge per admission or prospective target rate for the prior year. In those cases where the average billed charge is lower than the target rate, 50% of the difference between the two amounts will be added as an incentive reward. This amount will then be multiplied by a new price adjustment index to determine the hospital's new prospective target rate. All other methodologies will remain the same as in the first year, with one exception. Hospitals exceeding their target rates in the prior year may be paid a percentage less than full billed charges to minimize the amount of year-end pay back.

Price adjustment indices will be established and announced by Blue Cross prior to the beginning of the year. The base that will be used initially to establish the index will be the Merrill Lynch forecast of the AHA marketbasket index, adjusted to reflect historic Region 8 trends. Changes to the base may be made in subsequent years to ensure that the price adjustment index is in line with local and national trends.

Exclusion of Outliers

Admissions subject to prospective payment are those with billed charges under $15,000 or lengths of stay under or equal to 14 days. Admissions with billed charges or lengths of stay over these amounts will be considered outliers and excluded from the program. The reason for this is to protect hospitals from being penalized at the end of the year because of unusually expensive cases. Payment for outliers will be made independently at 90% of billed charges.

Exclusion of Medically Unnecessary Admissions

Blue Cross will continue to review the appropriateness of Blue Cross admissions, including transfers. In those cases where an admission is deemed unnecessary, two actions will be taken. Payment will be denied, as it has in the past, and the admission will be excluded in computing the hospital's average billed charge per admission at the end of the year.

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Adjustments

Four types of adjustments will be made to hospital's prospective target rates: (1) adjustments for efficiency; (2) adjustments for changes in case mix; (3) adjustments for changes in capital; and (4) adjustments for changes in billing practice.

1. Adjustments for Efficiency. At the beginning of the year, each hospital's average billed charge per admission will be compared on a case mix adjusted basis with those of other hospitals within its peer group. Two peer groups will be used based on bed size: hospitals under 100 beds; and hospitals with 100 or more beds. Hospitals whose billed charges are below 80% of the median for their peer group will receive a 1% bonus applied to their prospective target rates. Hospitals with billed charges above 120% of the median will have their prospective target rates limited to the 120% level.

2. Adjustments for Changes in Case Mix. At the end of the year, an adjustment will be made to each hospital's prospective target rate to reflect changes in case mix. This will be done by multiplying the hospital's target rate by the percentage change in its Blue Cross case mix index between the prior and current year. Case mix indices will be computed using Medicare Diagnosis Related Group (DRG) weights, adjusted to a DRG base of 1 for Blue Cross admissions.

3. Adjustments for Changes in Capital. Adjustments will be made to hospitals' prospective target rates to reflect changes in capital costs associated with major capital projects. Major projects are defined as capital expenditures in excess of $200,000 for hospitals under 100 beds and $600,000 for hospitals with 100 or more beds. Adjustments for capital must be requested and will be subject to Blue Cross approval, unless prior approval has been obtained through Section 1122 review.

4. Adjustments for Changes in Billing Practice. Adjustments will be made to reflect changes in hospital billing practice, primarily related to the debundling of services and the billing of professional and technical fees. Hospitals will be required to notify Blue Cross 30 days in advance of all changes and provide information concerning the impact of the changes on inpatient hospital charges.

TIMING OF EVENTS

The first year of the program will extend from March 1 through December 31, 1984. Each subsequent years will start on January 1.

Computations of prospective target rates for the first year will be based on calendar year 1983 data available as of early January.

Computations of year-end pay back amounts and subsequent years' prospective target rates will be based on program year data available as of the end of February. The reason for this lag is to allow sufficient time for all hospital claims to be submitted and processed.

INCENTIVES FOR HOSPITAL PARTICIPATION

Hospitals which participate in the REWARD program will be considered member hospitals and will continue to receive direct payment from Blue Cross. They will have access to CRT's for electronic Blue Cross and Medicare claims submission when available. Quarterly management reports providing both historical trend and peer group comparison data will be provided.

Hospitals which are eligible for the program but do not participate will be considered non-member hospitals and will no longer receive direct Blue Cross payment. Payment for services rendered by these hospitals will be made to the subscriber in accordance with non-member benefit provisions.

SUMMARY

The REWARD program will bring about a significant change in the way Blue Cross reimburses hospitals throughout the state. The intent of Blue Cross in implementing the program is to introduce incentives that make sense in today's health care environment. We encourage hospitals to participate in the program and to work with Blue Cross in addressing the health care issues affecting our state.

Senator DURENBERGER. Mr. Hannah.

STATEMENT OF FREDERICK H. HANNAH, GTE COMMUNICATIONS SYSTEM

EMPLOYER PAYS COVERAGE FOR EMPLOYEES

Mr. HANNAH. I am Fritz Hannah with GTE at the Albuquerque plant, and I want to say thank you for this opportunity to hear one small voice in a huge problem.

Consideration of any medicare reform must include consideration of the total health care delivery system we have created in the United States. For many years, employers have provided more and more health care benefits for employees at less and less cost to them. Employers have, for example, reduced deductible amounts to token levels, reduced the portion of premiums paid by employees, and provided more coverage. Employers, through their benefit plans, have paid the full cost of hospital fees; including room and board and services.

At the same time that employers were improving benefits for the employed population and their dependents, the Government was providing more and more benefits to the unemployed segment of the population. Hospitals and other providers of health care were providing care for that segment of the population not otherwise covered by benefit plans. They did so to a significant degree by shifting the cost of such care to the insured and to private-pay patients.

PRESENT HEALTH SYSTEM CAN'T BE AFFORDED

Therefore, we have made available a system of health care to our population which far surpasses any in the world. This is basically at no cost or very low cost to the individual. We have educated our population to consume too many health care services. At the same time, we have encouraged health care providers to consistently improve the level of the care that they provide.

In short, we have created a system of health care services which we, the employers, as well as the Government, can no longer afford. Thus, an examination of the impact of medicare reform must consider the total system we have created. Reduced benefit levels for the unemployed segment of the population means increased cost to the employed segment of the population and their employers. These increases have averaged 20 percent per year for the larger employers.

EMPLOYERS OVERHAUL EMPLOYEE HEALTH CARE BENEFITS

Increased costs have caused American business to change the way it thinks about its role in providing health care to employees. The employer is changing from a payer to a purchaser of health care. Some are becoming providers of health care through coalitions and in-house programs. However, for the employer, the more common approach to the problem of health care cost is to decrease the level of benefits and shift a portion of the cost of the care to the employee.

In the Albuquerque area, six of seven high-tech employers will implement major changes in their health care insurance this year. These changes will be shifting a portion of the cost to the individual employee, through establishing higher deductible amounts, lower benefit levels, reduced coinsurance levels, and increased out-of-pocket expense levels.

At the same time, the benefit levels are being reduced. Plans are now designed to discourage hospital stays and to reduce the number of unnecessary or nonessential admissions to hospitals. Six of seven high-tech employers require a second opinion for surgery and provide a penalty when the second opinion is not obtained. Plans which provide the type of coverage that encourage out-of-hospital care—such as outpatient benefit levels—have been increased to encourage use of day surgery and other outpatient care and treatment.

Home health care benefits are now provided where they were not in previous plans. Employers are providing educational programs for employees to encourage them to shop for health care, to discuss fees in advance of treatment, and to challenge charges and procedures in advance of treatment. One major employer in the southern part of the State has a program which pays employees one half of the savings they realize through challenging unwarranted charges.

PAYER AND PROVIDERS OF SERVICES SQUEEZE EMPLOYEES

Programs such as these have the negative effect of placing the employee in a position of being in the middle between the employ-

er who is placing the burden of added personal costs on the employee, and the provider of health care who has more and better care to offer. On the one hand, the medical community expresses concern that programs such as these will cause employees and their dependents to delay treatment and lower the level of their care.

On the other hand, health care economists tell us that we will "overconsume" health services. Employers are faced with the dilemma of intervening in a system which has always been considered to be a private relationship between the doctor and the patient. The diagnosis and care was the purview of the doctor, certainly not the employer.

To address these issues, employers are taking new approaches. One is to create a professional purchaser-supplier relationship on a nonconfrontational basis with the community of health care providers. This has been accomplished by establishing coalitions with the main purpose of providing a forum for ongoing communication among key leaders in the business and industrial community and the health care field. These groups have a top priority of addressing health care cost issues. We in the greater Albuquerque area are now approaching the second year of a coalition which shows some genuine promise of success.

Another approach to the control of health care costs taken by employers is to establish in-house, employer-provided wellness or fitness programs. These programs have the obvious intent of improving the health of employees and, through them, their dependents; and thus reducing the need for health care. These programs are proving to be beneficial for the employee population, but have an undetermined impact on dependents.

IN-HOUSE EMPLOYEE HEALTH SERVICES

The third, and perhaps the most difficult measure taken by employers, is to become more of a primary health care provider for employees. These programs consist of establishing in-house employee health services, providing a full range of programs from diagnosis through followup care. At GTE, we have adopted a relatively new approach providing a broad spectrum of care utilizing a staff of physician assistants trained in the industrial environment to meet these specific needs. The physician assistants have established large-scale screening, monitoring, and educational programs designed to train employees to take more responsibility for their health care and the services they purchase.

Screening and monitoring programs search for and manage such conditions as hypertension, diabetes, and the more common but important health problems. Through such programs, the employer is becoming more of a primary care provider than previously; more perhaps, than he would care to be. For example, in our plant of approximately 1,200 employees, the physician assistants experienced 3,441 patient encounters during 1983. Of these, 346, or 10 percent, were occupationally related and consisted of complaints such as cuts, scrapes, strains, sprains, burns, et cetera. Ninety percent, or 3,095 of these encounters were for nonoccupational conditions. In

these cases, employees did not have any medical expenses to pay out of their pockets.

These programs are seen as a key to reduced health care costs. However, they are not accomplished without cost to the employer. The objective is to get and keep employees fit, thus reducing total overall costs.

In summary, in the United States we have educated people to be the highest users of the most advanced and expensive health care system in the world. Benefits provided by the Government and by private employers through benefit plans have reached cost levels impossible to maintain.

With decreased payments provided by the government, employers are faced with increased premium rates. Employers are passing the burden of the increased cost on to the shrinking population of wage and salary earners. At the same time, employers are incurring the increasing cost of providing health care for employees in plants and offices. We are left with the hope that all these efforts will result in better employee health and, therefore, reduced expenditures for illness.

ALTERNATIVE HOSPITAL CARE

Changes in medicare should address the same issues employers face. Medicare should address the need to provide appropriate benefits and benefit levels with the same objective as private plans. Medicare should encourage out-of-hospital care and home care as well as alternative forms of care provided by physicians assistants, nurse practitioners, and other qualified providers and should include an emphasis of wellness as well as treatment for illness. Thank you.

[The following was supplied for the record by Mr. Hannah:]

Testimony by F. H. Hannah

APPENDIX A

Seven major electronics manufacturing companies with plants in Albuquerque were surveyed to determine responses to health care cost concerns. Five of the seven have implemented major health care program changes with cost containment features, incentives, and objectives; and a sixth company is currently considering changes.

Although there are variations in program details, there is a high similarity in program features. The following elements typify program approaches:

- o Increased employee share of program costs
  - Increased deductibles
  - Increased out-of-pocket maximums
  - Reduced co-insurance benefit levels
- o Incentives to reduce hospital costs
  - Decreased daily room-rate benefit
  - Increased benefit for outpatient surgery
  - Increased benefit for urgent care center treatment
  - Increased benefit for pre-admission testing
  - Extended-care-facility coverage
  - Home health-care treatment coverage
- o Incentives to reduce surgeon's costs
  - Second surgical opinions required
  - Benefit penalty for not getting second opinion

- Employee education and awareness programs
  - Extensive employee orientation meetings, films, and brochures to increase employee awareness and create a wiser and more cost-conscious consumer of health care services
- Other incentives
  - Two companies provide flexible spending credits in the range of $300 to $600 at the beginning of the year. Employees may charge costs such as deductibles or their share of co-insurance against these credits. Any unused credits at year end are returned to the employee as cash or rolled over into the next year's flexible spending credit or into savings programs.
- Other cost-containment features
  - One company requires coordination of benefits with automobile and homeowner insurance carriers. This prevents payment of health care benefits that have been paid by other than health care insurance carriers.

GROUP HEALTH INSURANCE
PROGRAM STATUS

ITEM	GTE	CO. A	CO. B	CO. C	CO. D	CO.[1] E	CO.[2] F
Major Change For Cost Containment	Yes	Yes	Yes	Yes	Yes	Being Considered	No
Effective Date	Feb '84	Jan '84	Jan '84	Jan '84	Jan '84	--	--
Increased Deductible	Yes	Yes	Yes	Yes	Yes		
Second Surgical Opinion Required	Yes	Yes	Yes	Yes	Yes		
Benefit Penalty For No 2nd Opinion	Yes	Yes	Yes	Yes	Yes		
Outpatient Surgery Paid Higher Benefits	Yes	Yes	Yes	Yes	Yes		
Hospital Benefit Reduced	No	Yes	Yes	Yes	Yes		
Co-insurance Benefit Reduced	Yes	Yes	No	Yes	Yes		
Pre-admission Testing Incentive	Yes	Yes	Yes	Yes	Yes		
Extended Care Facility Benefit	Yes	Yes	Yes	Yes	Yes		
Home Health Care Benefit	Yes	Yes	Yes	Yes	Yes		
Out-of-Pocket Max Increase	Yes	Yes	Yes	Yes	Yes		
Employee Education Program	Yes	Yes	Yes	Yes	Yes		
Coordination of Benefit with Auto and Homeowner Carriers	No	Yes	No	No	No		
Flexible Spending Benefit Credit	No	No	No	Yes	Yes		

[1] No recent group health care program changes but major changes are under consideration. This company has implemented health awareness programs including nutrition, stop smoking, aerobic exercise, and employee assistance programs.

[2] This company has not introduced new cost containment health care programs. Current benefits contain some features such as second surgical opinion and outpatient surgery incentives.

PROSPECTIVE PAYMENT FOR PHYSICIANS

Senator DURENBERGER. Mr. Sacco, let me ask you first about the Blue Shield side of the REWARD program. The program is obviously set up to provide a means for prospective payment for hospitals. What have you got in mind for the docs?

Mr. SACCO. It is interesting you should ask that. When our board adopted the resolution to have the prospective payment, it indicated that we ought to be developing a system of prospective payment for physician services as well. I think this morning you heard some testimony about the complexities of doing that, particularly in the outpatient setting. What we said was we would like to move incrementally by implementing our hospital-based program and then moving toward physician services. But as a comment, when you look at the payment for surgical services, it has historically been a global fee or very close to the DRG concept. That is, once a patient was identified as one in need of surgery from the screening visit in the office, through the followup visit after hospitalization, there has been a global charge.

So I think I am convinced that prospective payment systems for inpatient services probably can be developed, however, outpatient services are another matter, and I haven't heard any good ideas on that. But we are certainly looking at that matter.

BLUE SHIELD ALTERNATIVE CARE

Senator DURENBERGER. I think we all know historically that Blue Cross was developed as a reimbursement system for the hospitals, Blue Shield for the doctors. As time went on, that sort of changed. I know you still reimburse doctors and hospitals. What does Blue Shield of New Mexico know about reimbursing skilled or intermediate care nursing facilities or home health or the VNA programs, all that sort of thing, what do you know about that whole side of Albuquerque?

Mr. SACCO. As in our hospital-based reimbursement system, it has historically been billed charges, and all that with a review process. What we have done in the benefit structure is not address the rate of reimbursement but the utilization of service. For example, on the home health we said there has always been a basis for using home health in lieu of hospitalization as well as home health services posthospitalization. And there was a differential rate of reimbursement. But historically, unfortunately, we did a charge review process as opposed to digging in and developing cost incentives.

Senator DURENBERGER. As I look at your description of Reward, it doesn't seem to have the capacity, like our system would have, to enlarge itself into other providers. That may be a little unfair because it seemed to be aimed at hospital specific charges and you are adjusting from year to year off of a hospital's specific performance against that hospital's charges. If they start going into alternatives because of prospective payment, into skilled nursing and home health, and because of some of these other varieties, do you anticipate the Reward will also alter the approach to prospective payment?

Mr. SACCO. Two things would happen. I think we may either alter the amount of reimbursement through the Reward program or develop additional components based on levels of care that are utilized. This kind of shift has not yet happened so, frankly, we haven't faced it. We think the Reward program is probably adaptable to other types of providers, because one of the things that is critical to the Reward program is a screening that is based on peer group comparison. So not only is it based on each hospital's historic billed charges but we have created peer group comparisons and placed limits on the amount of charges per admission that would be recognized. And that approach, I think, could work for other provider types as well.

STORMY JONES AND BIOMEDICAL ADVANCES

Senator DURENBERGER. Do you know if nationally Blue Cross has taken a position in favor of—I am not at the end of your statement—a separate program to finance Stormy Jones and the biomedical advances?

Mr. SACCO. I think that on a national basis that would be the preference, but I think that we are also under significant pressure, and a number of plans have succumbed to that pressure, to fold in things like organ transplants. My feeling is that we are doing so before we are prepared to understand the consequences of those decisions. Massachusetts Blue Cross, for example, did it for a specific group as a specific option and that was a relatively expensive option, $28 per month per family, for a heart transplant coverage.

Subsequently they have made it more broadly available and my guess is they will see the impact of that on premiums over the next 2 to 3 years.

BENEFIT CHANGES PUZZLING

Senator DURENBERGER. Mr. Hannah, two questions. In your testimony on the list where you are talking of the six to seven high-tech employers implementing changes, and I think I can understand all the changes, the higher deductibles and coinsurance and so forth, I am not sure of why they are going to lower benefit levels and who is making that decision. Are the employers arbitrarily cutting out dental and mental health coverage or is it the choice of the employees to do less coinsurance in some benefits and get rid of benefits in the other areas; how is that working?

Mr. HANNAH. Some employers have gone to the cafeteria method of providing options for benefits and benefit levels. The plans that I have discussed, only those in the local area, are those where the benefit levels, the amount paid, for example, had been significantly reduced as opposed to what we used to reimburse. As 90 percent, now we reimburse at 80 percent of those levels.

Senator DURENBERGER. You are not implying that benefits themselves are being dropped out of the plan?

Mr. HANNAH. In some cases some are, but with this other change the emphasis is to out-of-hospital care. Other alternative forms of care, as opposed to some of the benefits that were there, for instance dental care, is being reduced in a number of plans.

Senator DURENBERGER. My last question is more general and it is because I appreciate the list that goes with employers changing from payer to purchaser. But there is one big element on there that I can't find. You say employers are being providers of health care through coalitions, in-house programs, they decrease the level of benefits, shifting a portion of it to employees, educational programs for the employees, in-house employee wellness or fitness programs, at GTE you are utilizing a staff of physician assistants, and so forth.

And then the bottom line here is, "Through such programs the employer is becoming more of a primary care provider than previously; more, perhaps, than he would care to be." And at the very end you say that medicare should address the need to provide appropriate benefits, and benefit levels should encourage out-of-hospital care and home care as well as a decrease in the level of payment. I have come to a different conclusion, that you and I should do nothing other than encourage choice. We don't have to get into the business of telling people they have to use second opinions and a whole lot of those other things, if we would just provide our employees with the opportunity to make choices from among health plans. I don't see that on your list of directions employers here are moving and maybe you can tell me why it isn't there.

Mr. HANNAH. Well, I think perhaps I implied that when I said we the employers have trained employees over the years to be vast spenders. We are now in the process of trying to teach them to be purchasers. The next step may be the areas you are addressing. I think we are not yet ready for that.

Senator DURENBERGER. Has it been explored in Albuquerque?

Mr. HANNAH. Yes; it has. We have talked about it on several occasions and most of us agree that these first essential steps have to be taken now. The other will come later. This is only the beginning.

EMPLOYEES POLICING MEDICAL CHARGES

Chairman DOMENICI. You mentioned, Mr. Hannah, that one of the employers down south was experimenting with a system of reimbursement for a portion of the actual savings resulting from the employee finding mistakes or overcharges. Do you know much about that?

Mr. HANNAH. Yes; but only that it has proven very successful and the employees are almost without exception getting some money back for each hospitalization and they are beginning to pay very close attention to the charges and kinds of charges and it has proven to have a beneficial effect in the first year of operation by some reduced overall costs of care. Really, I don't know anything more specific than that.

MOST COST-EFFECTIVE CURE NOT ALWAYS GIVEN

Chairman DOMENICI. Mr. Sacco, do you think there is a problem, and, if so, is it very serious, that relates to physicians on their own choosing among medications, among technologies, among services, of choosing less than the least expensive that will do the job?

Mr. SACCO. I am not sure I understand the question.

Chairman DOMENICI. Let me give you an example. Eighteen years ago I had a son that had an illness. At that point in time after recovery they said he would have to take penicillin all his life We found out 5 years later he didn't have to do that. But the penicillin then was $35 for each little bottle. Six months later I found that if I went to a certain place I could get a similar antibiotic, similar in all respects with reference to its curative and preventive effect. It was dramatic, like from $35 to $5. And then I found even a little bit further if I went to one of these other groups I could get it for $1.25. I don't give you this to say anybody is cheating, I just know that there is a choice. And I wonder if there is any problem with people not being concerned about the choice.

Mr. SACCO. I think there is. I think that is one of the fundamental problems in the system that we have seen to date, both for the hospital reimbursement and physician reimbursement. There were no penalties, if you would, or incentive to use the most cost-effective cure.

Chairman DOMENICI. How is that going to come into play in your Reward system? How is that going to come into play in our prospective DRG's?

Mr. SACCO. I think that because institutions will survive on the basis of being as effective as they can in both the administrative policies such as purchasing supplies and services, but more importantly in ordering services. There is going to be a tremendous wealth of data that is going to be generated and physicians will work as groups with pressures from within the hospital to identify those who go outside the standards, the norms, if you would. We have had TSRO's since 1972, but the penalties and pressures under the TSRO's have not really been tied to the fundamental reimbursement. I think this data will be used effectively, but it will take many, many years to turn that process around.

LESS TOLERANCE FOR ABUSE

Chairman DOMENICI. In your prepared statement you said: "Last, consumers will feel the effects. There will be less tolerance for use of"—and then if I read it right in your written testimony, you said—"for use of marginal services." When you said it orally you said, "for the use of discretionary services." Are they the same?

Mr. SACCO. I mean them the same. The example I meant would include the pressures to stay an extra day for patient convenience or because someone isn't there to pick up the patient or whatever. It is often a case where you have pressures to stay 1 more day to rest up before you go on and face the onslaught of kids at home. That kind of care I think is marginal or discretionary.

GEOGRAPHICAL DIFFERENCES MUST BE CONSIDERED

Chairman DOMENICI. Just one last question of each of you. It appears to me that you both have told us about your responsibility in moving with plans to deliver less expensive, but as good as possible, health care. Both of you have told us that you do it in a way very unique to those you are working for. Yours is being developed for your particular needs at GTE. You are working on one that seems to fit New Mexico, if I read you right.

Mr. SACCO. I do think it fits New Mexico.

Chairman DOMENICI. Does that tell us that it is going to be very difficult for us to develop things nationally unless we are acutely aware of the differences in States and regions and systems and the like?

Mr. SACCO. In my opinion, the problems across the country vary so significantly that the solutions must as well. So that within the framework of any national legislation there must be latitude to look at State situations that make more sense given the confines of geography.

Senator DURENBERGER. Why should it cost more to take out an appendix in Minnesota?

Mr. SACCO. There is no adequate reason for that that we have found, but I think that is a good illustration of the different nature of the problem. In the Northeast the average length of stay per hospital is 8.3 days. Here in New Mexico it is 6.32. The solution to the Northeast problems may very well be different than the solution to some of our own cost problems in New Mexico, because the definition of the problem is different. We are more efficient here. We may need different answers.

Chairman DOMENICI. You have the highest taxes in the United States in your State. That has more to do with it. You are losing all the business you used to have there.

Senator DURENBERGER. Next you are going to pick on our football team.

Chairman DOMENICI. I wouldn't dare do that. I just want to tell you, Mr. Hannah, that I must come out there and visit you.

Mr. HANNAH. I wish you would.

Chairman DOMENICI. I was the one that talked to your former chiefs in San Francisco in moving that plant to New Mexico. It was great fun to convince them that this was the right place. But I was so good at selling them out there in California with my little Albuquerque tale, that we were so great, that they looked at me and said, "If Albuquerque is so good, how come there aren't any businesses like ours out there?" That was pretty hard to answer. I fudged around a little.

Mr. HANNAH. We have shown them why they should be here.

Chairman DOMENICI. It is easier now. Thank you very much. I appreciate your coming.

William Johnson, the administrator of the University of New Mexico Hospital. We are delighted to have you. I understand, Bill, we have Virginia Crenshaw and Rita Maes to follow you, and that means we ought to be right on time. You have about 10 minutes for your opening remarks. Thank you for coming.

STATEMENT OF WILLIAM H. JOHNSON, JR., ADMINISTRATOR, UNIVERSITY OF NEW MEXICO HOSPITAL

Mr. JOHNSON. Thank you very much. I did bring some slides with me. I would like to show those.

Chairman DOMENICI. Sure.[1]

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[1] See Mr. Johnson's prepared statement beginning on p. 161.

Mr. JOHNSON. You may have to sit catty-cornered. I think it might be more graphic, rather than talking in dollar numbers alone.

HOSPITALS FACE INDIGENT PROBLEM

Senator Domenici and Senator Durenberger, I am Bill Johnson. I am the administrator at the University of New Mexico Hospital. I have been asked to discuss briefly with you today the question of independent medical care. Before I begin, I would indicate to you that the problems that I will discuss today are not associated only with my hospital and the State of New Mexico, but these are national problems. All of the hospitals in New Mexico face some problem of varying degree with indigency. I thought that it might be helpful if I brought you through the University of New Mexico Hospital briefly, inasmuch as it is an academic health center, and it is representative of most of the types of public hospitals that serve concentrated populations of indigents.

In that regard, I would indicate that we are an acute, tertiary care hospital that serves with the highest level of technical medicine. We also service the intercity, barrio, ghetto, referral, any kind of a hospital thing that you would like to attribute to us.

We operate 273 acute care beds and 47 bassinettes. It is interesting to note that our hospital is the 10th largest employer in the city of Albuquerque and I think that frequently it is overlooked. When we determine the fact that we have health care costs, there is in fact some payback into the community. We will expend $52 million in the State of New Mexico; 65.1 percent of that being in terms of salary. So we also provide something back to the community.

We are an organizational part of the University of New Mexico Medical Center, which is an organized health delivery center which provides a broad spectrum of health services within the community. We do things that are unique. We take care of indigents. We run a trauma center. We have a high-risk pregnancy center. You can read the variety of activities that we are engaged in which is leading me to the point that the mission that is assigned to the teaching hospital, to the patient care teaching and research, creates financial strains on the institution that are perhaps not in other kinds of community hospitals, in addition to the problems with indigent care.

To give you a sample of the types of patients and types of admissions that take place, we find that we have a very active, busy institution. I think that of particular interest is on the outpatient vists and emergency room visits. We provide frequently the broad spectrum of care to patients who would have no primary physician in another setting.

LARGE PORTION OF MATERNITY PATIENTS WITHOUT FUNDS

If one looks at some of the medically unserved areas right here in Albuquerque, in the South Valley there are three primary care physicians for 90,000 patients. We in fact take a large part of the walk-in, indigent, nonpaying kind of a patient.

Senator DURENBERGER. Isn't that a big emergency room population? Isn't that a lot of business?

Mr. JOHNSON. Yes; it is a large business for the size of our hospital and for the community. We are probably going to do about 37,000 visits this year. If I could just back up for a moment, we talked at lunch about live births. Of the 2,426 we have, 75 percent of those patients had no money and made no payments. That amounts to $2.2 million. One of the interesting things is that 30 percent of our resources is devoted to care of children and the numbers are very explanatory. The teaching mission—after our patient-care mission—we have a thousand students a year in our hospital, frequently providing health care throughout the State of New Mexico, particularly in rural areas.

The teaching mission is costly. We receive no remuneration for that service. And to give you an idea, the cost of house staff salaries that the hospital must pay, the 90 house officers who are in training, is about $1.8 million. That is another expense borne by our institution which is not shared by other community hospitals.

When we look at research, and we hope that our country is based on new knowledge, and growth and development, you can see the broad type and varied research that is performed: aging. As I become older, that becomes of more interest to me. We have the diabetes studies with the insulin pump, et cetera; meaningful research in which we provide a basis for future growth of health in our country.

NONREIMBURSABLE AND FREE CARE

If we want to look at a more national level, I think it is interesting to note that the American Hospital Association/Urban Institute has begun to try to look It has done a 2-year study of 1980 and 1982 on what is taking place with the poor in America. The numbers are $13.4 billion in care for the poor, with only $8.9 billion paid by medicaid for the Federal support, $4.4 billion free care. And I heard one of you mention there is no free lunch. That is shared by somebody and paid for by somebody.

As I look at this, if we look at the public hospitals in the 100 largest cities in America, 22 percent of the resources are devoted to free care. And the public hospitals throughout the community, such as Las Cruces and et cetera, it runs about 8.5 percent of their resources. And teaching hospitals, Mayo and some others which are counsel-teaching hospitals, is 4.4 percent. And the nonteaching hospitals are about 3.3 percent.

If you look at the University of New Mexico Hospital, as a percent of our resources devoted to free care, our discounts and allowances, in our hospital it is approximately 41 to 42 percent. That means that in the last fiscal year I wrote off to bad debt, free care, contractual allowances, about $29 million; and I have an illustration of that later on. If you look at the total of beds within the country and in the hundred largest cities, you will find that for the total beds, the public hospitals have 5 percent of the total beds in the country, 26 percent with the nonprofit, and 3 percent for proprietary.

But if you begin to look at care for the poor as opposed to medicaid and medicare, you look at the charity care figure, which is free, and bad debt which is free, you are looking at about 59 percent of that business that is done by 5 percent of the hospitals. I think that is rather dramatic statistics. In the State of New Mexico, if we try to look at the indigent problem, and I have the figures that are appropriate to my hospital, I think that the growth rates that you will see visually are similar throughout all of the hospitals in the community.

SELF-PAY PATIENTS MISNOMER

I have indicated to you in this chart from 1979 to 1983 the indigent health care in the cross lines and self-pay. Now self-pay, gentlemen, is a misnomer. In our hospital, only 23 percent of the self-pay ever pays. The self-pay category, in most hospitals, are the working poor, those individuals who are employed. They may have a wife, three children, they have a small business, or they are working for a firm that does not have health insurance, or they have not elected or cannot possess or purchase health insurance on their own and in fact have some medical catastrophe. Two years ago we had 50 people who had contracts through our hospital in excess of $2 million, paying them off at $10 and $15 a month.

You can get some focus on what self-pay means if you look at the billing of self-pay, $14.5 million, and the amount of cash collected against those billings was $2.6 million, as opposed to insurance revenue in cash, where you have in fact billings and cash in a quite different relationship.

That is supposed to be $21 million. We put the wrong figure. You can see, I think, that it is a question of cost shifting, which has not been discussed greatly this morning, but I think that is a clear illustration. I have a large number of people I bill that don't pay. I have a group of people that I bill and they pay more than other people do. I think this illustrates some of the problems that we are talking about. If you want to look at the growth of indigent revenues, and these are billed charges, the growth has been steady. It has been increasing. This is total indigent within the State of New Mexico, out-of-county and in-county.

And if we want to look at what is taking place with just the out-of-county we have seen again that steady picture of growth. And we are talking about, as I go back to county, the millions of dollars, approaching $10 million, and in this other case approaching almost $1.5 million of indigent care, remember, this is our institution alone.

One of the problems is that the local, State, and county governments have been unable to continue to support the growth of health care costs for indigents. And if you look at the crossed lines you will see the level of increase in appropriations to our hospital since 1979, and the growth of our discounts and allowances to write off in all cases, not only indigents.

Senator DURENBERGER. What does the word "unable" mean? You said State, local and county have been unable.

Mr. JOHNSON. Should I say unwilling?

Senator DURENBERGER. One or the other.

Mr. JOHNSON. I have got to stay good with the county. The increase has not been in comparison to the growth. Again, if we look at the local mill levy in Bernalillo County, which is our major support, it was $6.8 million last year. If you look at the indigent and self-pay, clearly the growth has been undramatic in revenue or appropriations. I recognize that the growth is not just our patient workload, that inflation and rate increases have in fact changed some of the activity. I think it gives you some sense of the general growth.

FISCAL 1983 WRITEOFFS

If you want to look at our hospital, for fiscal year 1983, and we try to enhance and we try to not overstate our case, we had discounts, allowances, writeoffs of $28.9 million. We have extracted from those, those contractual allowances that we believe every hospital has a problem with, remembering that that money is still not available. It is gone. And we have had contractual allowances of $7.5 million, leaving a net of $21 million.

We have said, "All right. We will apply writeoffs and subsidies that we receive, to be honest about it." That was $8.5 million. When you net it out, it is $12.9 million of uncompensated care in one hospital in the State of New Mexico for which there was no reimbursement whatsoever.

In the case of the university, that does not include an additional $7 million of professional fees for physicians, which are not charged against indigent care. So we are looking at approximately $2 million of health care being provided by one institution in the State.

STATE PAYMENTS FOR INDIGENTS

Senator DURENBERGER. Can I ask you one other question? I am left unclear. What is the State of New Mexico's role in all of this? Where will I find State appropriations?

Mr. JOHNSON. If you took the mill levy, the $6.9 million that represents the four mills in the property tax dollar from Bernalillo County——

Senator DURENBERGER. That is local?

Mr. JOHNSON. The special? Out of county? Indigent? Which ones? The neonatal? On the out-of-county expenditures over the past 5 years there has been periodic infusion of capital and equipment for the activities within the hospital.

Senator DURENBERGER. That is not other counties paying?

Mr. JOHNSON. That is the State of New Mexico giving to us that appropriation for the payment of indigents from out of Bernalillo County. There are other counties within New Mexico that have indigent funds. Only two counties, Dona Ana and Santa Fe, have any funds of any substance. The funds are managed differently in each county. Some will only pay to their hospitals. Some will pay for hospital care only but not physician care. One of the things that Mr. Shaver was referring to was perhaps that these county funds, which are managed rather autonomously, if they were in fact put together with the medically needy program there could be a multi-

plier of Federal sharing which we are not taking advantage of at this time. But the State funding is approximately $1.8 million.

VARIETY OF FACTORS INFLUENCE HOSPITALS

All public hospitals have a variety of factors which are currently influencing them and these influence us. As you know, on the 30th of June the certificate of need law was sunset, followed by a proliferation of hospitals and provider activities. Our increasing discounts and allowances change as the percent of gross revenue changes. The Federal payment system. The competitive marketplace. The mill levy campaign for us is critical. We have to campaign for that. That is the same as if we were running for office. Then the parking.

Every public hospital I have been in has a parking problem. When you have parking problems people don't come there. Every public hospital I have gone to has ambulatory care problems. And these are influencing our institution as well as other public hospitals, in light of very, very difficult situations to begin with. If we were to say we only had problems, I guess, we would all leave and go home. I think public hospitals, as our hospital, are doing things that we believe will provide a future, an exciting one.

We talked about prospective payment, management-physician cooperation, physician-staff education. We are glad for our data processing to give us management information on a timely basis. Aggressive purchasing practices. Because of bundling rules we have had to be most careful. We are looking at joint ventures with other activities. Presbyterian Hospital and our hospital are looking at the best way to do the neonatology. We are looking to increase our market share. Identifying unmet medical needs. Geriatrics is something that perhaps is not being done as well as we should do it.

Alternatives to hospitalization, controlling expenses, improving our community image, et cetera, those are the things that we are trying to deal with in the future and the things that we have done in the past. I think we have responded to crises.

In our hospital the length of stay in 1979 was about 6.1 days. We have had this reduced by 5.6 percent in 5 years. We have looked at the inpatient surgery and that has taken a 12.6-percent increase over the time, but at the same time we have in fact had a 43.8-percent increase in the outpatient day surgeries, all trying to meet these new requirements of health care.

The question of medicare and what that will do to us in the public hospital, we have tried to look at those things that we would consider to be favorable. And clearly the indirect education factor in the teaching hospital will probably be the thing that will be able to keep the doors open. That hangs outside the system. It is vulnerable. It is obvious. We have had some concerns. If that was to be removed then our hospital would not be able to operate in a positive cash flow basis. We do think that medicare will improve cur cash flow. It is causing us to shift to a greater business orientation in how we do our business. I think that is healthy.

We are going to be required to understand, very much like Mr. Hannah from GTE, what product line comes off of patient care.

There will be incentives to plan and choose the least expensive care plans. I think the outcomes will be favorable.

But, on the other hand, we look at the problems associated with medicare, and that the New Jersey system had a very favorable outlier program which is not in the medicare system. We are looking at an admitted HCFA inadequate system based on 1979 data with as much as 37 percent error rate in coding. We would be afraid that considerable unfavorable diagnostic groups would be moved to our hospital, because it is unprofitable. Unfortunately, the hospitals have become the policemen and enforcers of the system.

I now have to go out and negotiate on behalf of the patient for nonphysician providers. We have to work closely with the physician in which there is no way for us to control the manner in which they do this. Cost shifting is encouraged. The system also calls for cost shifting as we try to move that on to a variety of other providers. Intermediaries, as you heard from Mr. Sacco, and Blue Cross and Blue Shield, are not willing to do that.

INCREASE IN HOSPITAL OPERATING COSTS DUE TO DRG'S

As I was told by Mr. Sacco, and I agreed with him, insured companies and not-for-profit intermediaries understand the problem on the indigent's side, they understand the nobleness of teaching, but they feel that that is not a responsibility of subscribers of purchasers of insurance but that there needs to be other ways of doing this. Will we see in fact discarded hospital services as they become unprofitable, and in fact increased hospital cost by matching the system? All hospitals are reporting substantial increases in operating cost to run the DRG system as a byproduct.

We are proud of our hospital. We are proud of its role within the community. We have never denied our mission to indigents, but we see grievous pitfalls in the future if the system does not work, and we have to be discouraged, that in spite of the guidance provided by the Congress, both the Senate and the Omnibus 1981 and the TEFRA legislations, that hospitals as ours should be accorded some protection because of our disproportionate share of the medical needy and indigent. Those protections have not been recognized or forthcoming.

Senators, that is my presentation.

[Mr. Johnson's full prepared statement follows:]

TESTIMONY OF WILLIAM H. JOHNSON, JR.
TO U.S. SENATE COMMITTEE ON BUDGET
February 15, 1984

Good morning. I am Bill Johnson, Administrator of UNM Hospital. I would like this morning to briefly present to you some information and thoughts relative to the provision of indigent medical care at both the national and local level.

In as much as UNM Hospital is the principal community resource for the major portion of indigent or charity care in the state of New Mexico, I believe a short description of UNMH would be both informative and insightful relative to indigent medical care. This is especially so since UNMH shares many of the same characteristics and problems as the majority of the public hospitals throughout the country.

UNMH is an acute care, tertiary, public, teaching hospital that serves as a medical resource as well as a referral center for all of New Mexico and in some instances, adjoining states (slide #1).

Not only is UNMH a major medical force in the state but we are also a significant economic entity contributing to the overall health of the economy (slide #2). For example, our expense budget this year will approximate $52 million dollars, the bulk of which will be expended in New Mexico.

Organizationally we are a component of the UNM Medical Center (slide #3) and we perform a broad spectrum of missions that are normally associated with an academic health center hospital (slide #4). The three fundamental missions of UNMH are patient care, teaching and research (slide #5). In the area of patient care we provided medical services in 1983 at the following workload levels. Of special note are the outpatient and ER visits. In many instances

we furnish to our patients a full continuum of medical care as many have no primary physicians receiving all medical care at UNMH (slide #6). Approximately 30% of our patients are from out of Bernalillo County. Additionally, it is interesting to note that children represent a significant portion of our workload (slide #7).

In our teaching role we educate and train the majority of the health professionals and allied health personnel that eventually are health care providers throughout the state (slide #8). However, this teaching mission generates additional operational expenses for the hospital, a cost which is not borne by other community hospitals. As you can see, the cost of houseofficer salaries alone was an expense of over $1.8 million in FY 1983 (slide #9).

The third essential dimension of an academic health center hospital is research. You will note that UNM Medical Center supported by UNMH is engaged in a wide variety of exciting medical research (slide #10).

This necessarily brief introduction to UNMH as a public hospital with a large indigent population not only describes our institution but gives insight to the two other facets, teaching and research, common to many public hospitals that adds substantially to the financial strain of operating a health facility of this nature. This is the reason you have heard so many requests from so many sources to provide some special financial treatment for these unique hospitals.

On a national level the major concern of public hospital managers in providing care to the indigent is if these hospitals will in fact survive the cost of accomplishing the tridimensional missions normally assigned to them.

To illustrate the level of concern, I refer to information contained in the January 16th issue of Hospitals Journal from AHA. They indicate that hospitals

serving the poor are in a serious bind. Either they maintain their service to the poor, endangering their fiscal health, or they reduce or ration care they deliver. To identify and publicize this problem, the American Hospital Association is participating with the Urban Institute in a study of the relationship between hospitals' financial status and care to the poor from 1980 to 1982. Highlights from a 1980 survey of the nation's short-term, not-for-profit and nonfederal hospitals indicates the following:

In 1980, these hospitals provided $13.4 billion in care to the poor, measured in full, established charges. Medicaid financed almost two-thirds of this care; the remainder was charity and bad debt (free care). Public hospitals in the 100 largest cities devoted an average of 22 percent of their resources to free care. This figure averaged between 8.5 percent and 5.5 percent for public hospitals elsewhere. At UNMH in FY 1983 the dedication of resources to this type of care is dramatic. (slide #11 and 12). Clearly, this level of resource devoted to free care cannot continue indefinitely. Not indicated in this data is the $7 million plus dollars of professional fees not billed for free care by UNM faculty. Private hospitals devoted a smaller share of resources to free care, with averages ranging from a high of 4.4 percent for Council of Teaching Hospitals (COTH) members to a low of 3.3 percent for nonteaching hospitals in metropolitan areas.

Nationally, care to the poor was highly concentrated in a relatively small number of hospitals. Only 16.5 percent of the hospitals spent more than 18 percent of their resources or $9.6 million per hospital on Medicaid, charity, and bad debt. Yet, they accounted for more than half of hospitals' total care to the poor. While 35 percent of all nonfederal hospitals are public, more than half of the hospitals heavily involved in serving the poor were publicly owned. Many were COTH members.

Although not all high volume providers to the poor experienced financial deficits, high volume providers were twice as likely as low volume providers

to lose money in 1980. An estimated 300 high volume providers ran bottom-line deficits. These 300 hospitals, just over six percent of all short-term, nonfederal, not-for-profit hospitals, provided one fifth of the hospital care received by poor people.

Deficits resulted mainly from lower revenues, not higher costs, per-patient day and outpatient visit. Stressed high volume providers had smaller shares of charge-paying, privately insured patients and larger shares of cost-based or regulated payers than their sound counterparts. Many of these stressed hospitals were in the Northeast. I believe the data provided by the AHA and the Urban Institute relative to care to the poor by ownership is most revealing (slide #13). Note the burden for care of the poor undertaken by the urban hospitals.

In New Mexico the growing problem of indigent care may be readily seen from this next slide. Both indigent and self pay billings have steadily risen from 3.6 million and 8.5 million dollars in FY 1979 to 9.5 million and 14.7 million dollars in FY 1983. Although some of this increase is attributed to inflation and rate increases the growth of indigent costs are substantial. I have included the self pay category in this presentation as the understanding of this patient category is essential to any understanding of the full financial impact on the public hospital. As a result of free care this classification of patient payment mainly reflects those individuals that are the working poor. Honest, hardworking citizens who for varied reasons have no health insurance but are not eligible for any public sponsorship in the event of a major medical emergency. At UNMH only 23% of self pay patients ever pay their bills and their accounts are transferred (slide #14) to bad debt. Note the disparity between billing and cash received (slide #14a). These next slides demonstrate the steady growth of indigent care costs to UNMH (slide #15 and #16).

The unfortunate aspect of this situation is that state and local funding has not increased relative to the cost of indigent care. This slide demonstrates

the dramatic increases of UNMH free, charity and bad debt medical care while local appropriations have remained relatively stable (slide #17).

UNMH as well as all public hospitals face an increasingly difficult task. Our mission has always been extremely challenging to manage in the past but the factors listed before you creates an even more interesting situation. Although the list before you is directed to UNMH, I am certain similar lists exist at each public hospital across the nation (slide #18). These are only representations of additional problems for public hospitals and their missions of providing care.

If one is to only lament and wring hands then there is no future. To survive, UNMH, as well as all hospitals, must do things differently than in the past. Again, this slide reflects our survival strategy, but similar efforts are on the table in all public hospitals (slide #19). I believe that earlier efforts to reduce the cost of health care have in fact had positive results in lowering health care costs. Length of stay decreases and inpatient vs. outpatient surgery changes have already demonstrated our ability to respond to critical situations; however, the public hospital system has already functioned in a precarious fiscal posture for many years. The new payment incentives enacted in Omnibus '81 and the recent TEFRA legislations will exert even greater stress on the public hospital especially in caring for the indigent.

These lists are what we consider both the favorable and unfavorable aspects of the new Prospective Payment System. (Slide #23 and 24). With the public hospital at fiscal risk, it is very disconcerting that HCFA has consistently disregarded the direction of the congress to develop special provisions for those hospitals that provide a disproportionate share of service to the poor and medically needy. If the public hospital system becomes bankrupt we will face a grave crisis in our country's health delivery system.

I believe there is much potential for creative and innovative solutions to the crisis in health costs. At the same time, there is the same potential for utter disaster in the industry.

Slide 1

WHO WE ARE

UNIVERSITY OF NEW MEXICO HOSPITAL
BERNALILLO COUNTY MEDICAL CENTER

ACUTE, TERTIARY CARE HOSPITAL

273 Beds

47 Bassinettes

Slide 2

UNMH - WHO WE ARE

UNMH EMPLOYEES

1,636 EMPLOYEES

225 RESIDENTS

266 ACTIVE MEDICAL STAFF

UNMH IS THE 10TH LARGEST EMPLOYER IN ALBUQUERQUE

Slide 3

UNMH - WHAT WE ARE

WE ARE PART OF THE UNIVERSITY OF NEW MEXICO MEDICAL CENTER

- UNM HOSPITAL
- CANCER RESEARCH & TREATMENT CENTER
- BERNALILLO COUNTY MENTAL HEALTH/MENTAL RETARDATION CENTER
- CHILDREN'S PSYCHIATRIC HOSPITAL
- SCHOOL OF MEDICINE
- ALLIED HEALTH SCIENCES PROGRAMS
- MEDICAL CENTER LIBRARY

Slide 4

UNMH -- WHAT MAKES US SPECIAL

- CARE OF INDIGENT
- LEVEL I TRAUMA CENTER
- HIGH RISK PREGNANCY
- PEDIATRICS
- NEONATOLOGY
- KIDNEY TRANSPLANT
- "LIFEGUARD" HELICOPTER
- MICROSURGERY
- ORTHOPAEDIC REIMPLANTATION
- 63 OUTPATIENT CLINICS

Slide 5

UNMH - WHAT WE ARE

WE ARE A UNIVERSITY TEACHING HOSPITAL--OUR COMMITMENTS:

- PATIENT CARE
- TEACHING
- RESEARCH

Slide 6

UNMH - WHAT WE DO

PATIENT CARE

1983 STATISTICS

ADMISSIONS	14,945
OUTPATIENT VISITS	105,686
EMERGENCY ROOM VISITS	32,318
OPERATING ROOM PROCEDURES	5,953
DAY SURGERY VISITS	1,044
BIRTHS	2,426

73% of our patients are from Bernalillo County

27% are from the rest of the state and out of state

Slide 7

UNMH - WHAT WE DO

CHILDREN

30% OF OUR RESOURCES ARE DEVOTED TO THE CARE OF CHILDREN

- 26% OUTPATIENT VISITS
- 27% O.R. SURGERIES
- 30% PATIENT DAYS

Slide 8

UNMH WHAT WE DO:

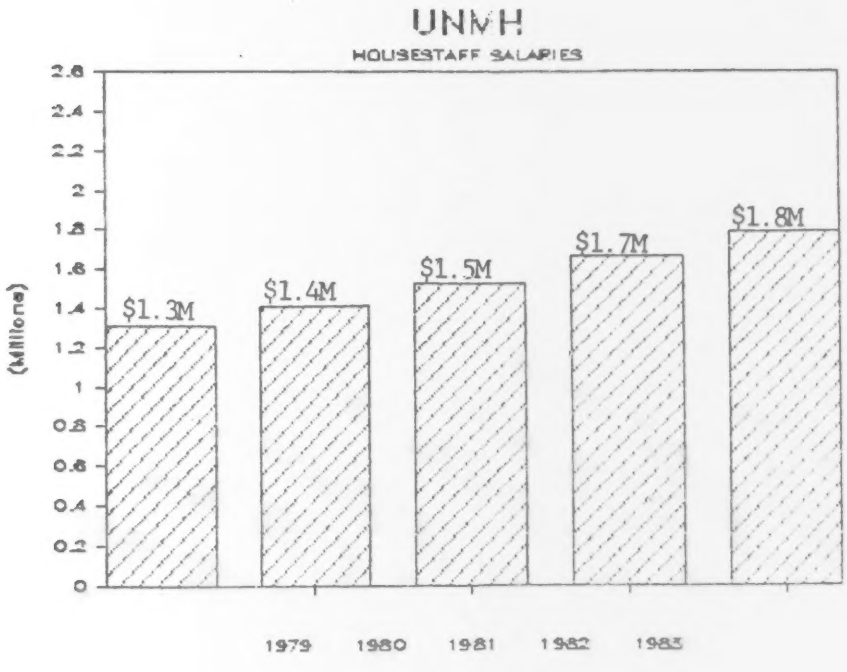
TEACH

WE PROVIDE LEARNING OPPORTUNITIES FOR OVER 1,000 STUDENTS EACH YEAR

- MEDICAL STUDENTS
- NURSING STUDENTS
- DIAGNOSTIC RADIOLOGY TECHNICIANS
- NUCLEAR MEDICINE TECHNICIANS
- PHARMACISTS
- RESPIRATORY THERAPY TECHNICIANS
- PHYSICAL THERAPISTS
- PARAMEDICS
- AMBULANCE TECHNICIANS
- MEDICAL TECHNOLOGISTS
- OTHERS

32-906 O - 84 - 12

Slide 9


UNMH
HOUSESTAFF SALARIES
(Millions)
2.8
2.4
2.2
2
1.8
1.6
1.4
1.2
1
0.8
0.6
0.4
0.2
0
$1.3M
$1.4M
$1.5M
$1.7M
$1.8M
1979
1980
1981
1982
1983

Slide 10

UNMH - WHAT WE DO

RESEARCH

- CONSEQUENCES OF ILLNESS IN AN AGING POPULATION
- PREMATURE HIGH RISK INFANTS
  - HEART FUNCTION STUDIES
  - ANTIBIOTIC STUDIES
  - INFECTION STUDIES
- DIABETIC STUDIES
  - INSULIN PUMP
  - ARTHRITIS IN DIABETICS
- IMPROVEMENT IN BLOOD TRANSFUSION TECHNIQUES
- TREATMENT OF DWARFED CHILDREN
- OTHERS

Slide 11

AHA/URBAN INSTITUTE

HOSPITALS' CARE TO THE POOR IN 1980

$13.4 Billion Care for the Poor

$ 8.9 Billion Paid by Medicaid

$ 4.4 Billion Free Care

Slide 12

AHA URBAN INSTITUTE
HOSPITALS' CARE TO THE POOR - 1980

	% of Resources Devoted To Free Care
Public Hospitals - 100 largest cities	22.0%
Public Hospitals Elsewhere	8.5%
Private Teaching Hospitals (COTH Members)	4.4%
Private Non-Teaching Hospitals	3.3%

Slide 13

AHA/URBAN INSTITUTE

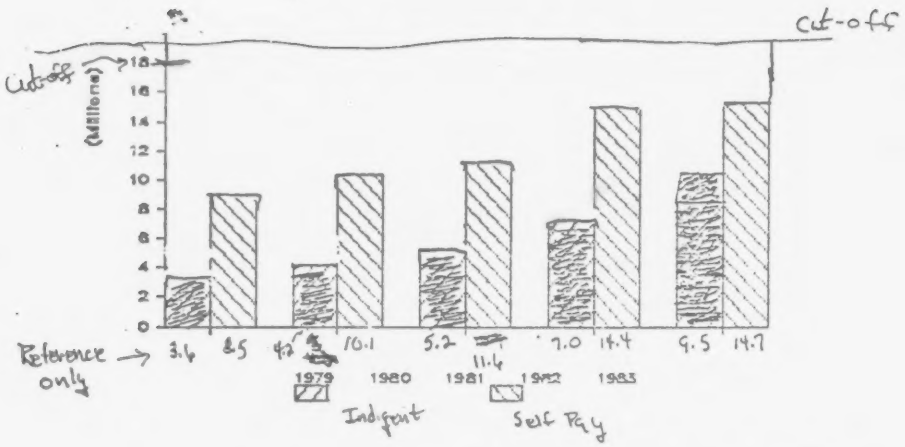
HOSPITAL CARE TO THE POOR BY OWNERSHIP

	PUBLIC	NON-PROFIT	PROPRIETARY
TOTAL BEDS	5%	26%	3%
CARE FOR THE POOR	17%	34%	2%
CHARITY CARE	40%	23%	0.1%
BAD DEBT	19%	26%	3%
MEDICAID	12%	40%	3%

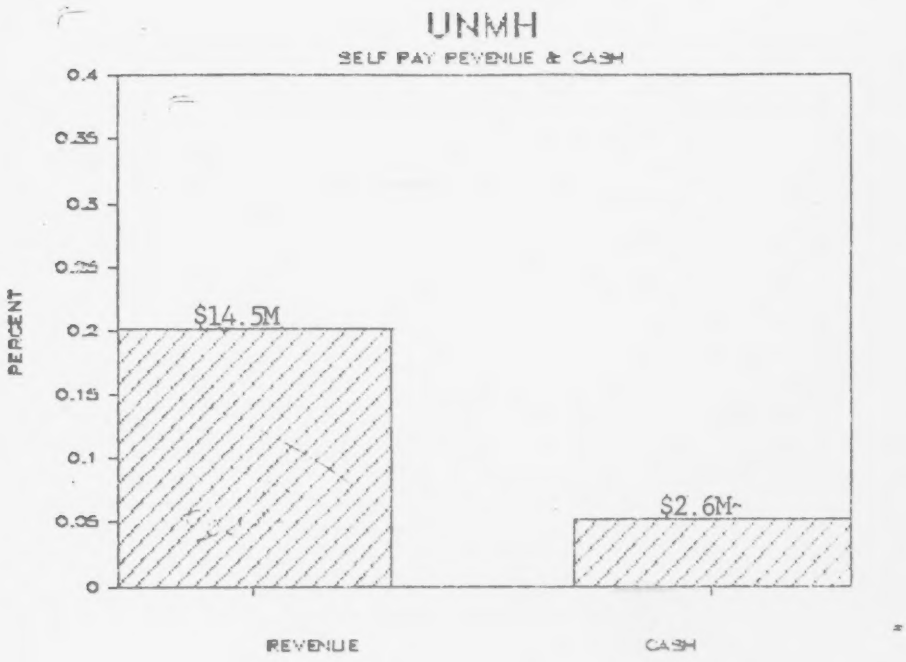
Slide 14

UNMH

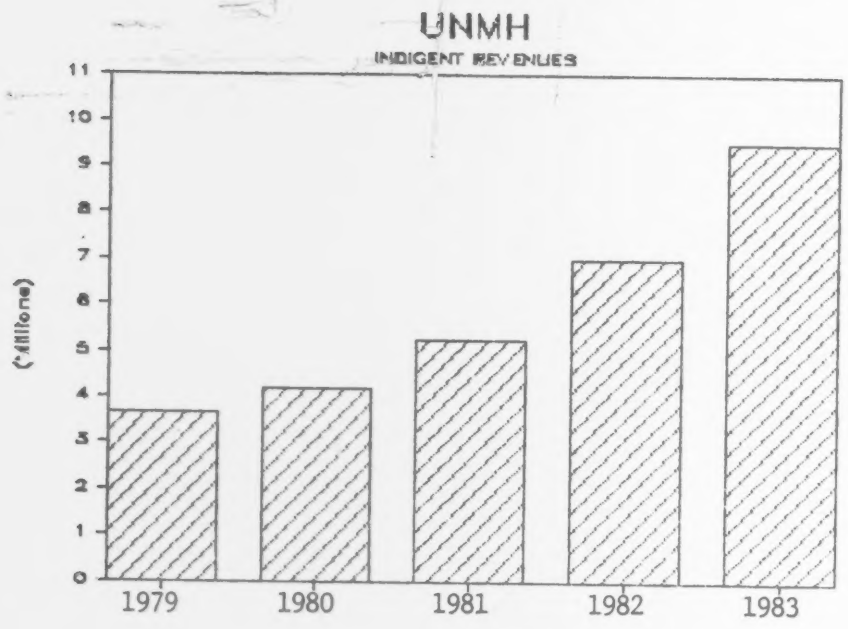
Indigent + Self Pay Revenue



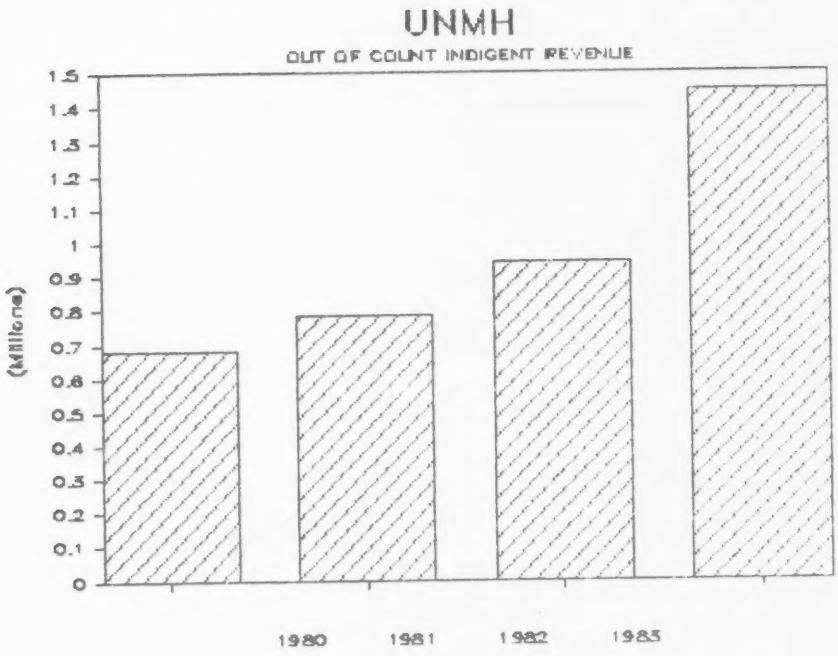
Slide 14a


UNMH
SELF PAY REVENUE & CASH
PERCENT
0.4
0.35
0.3
0.25
0.2
0.15
0.1
0.05
0
$14.5M
$2.6M
REVENUE
CASH

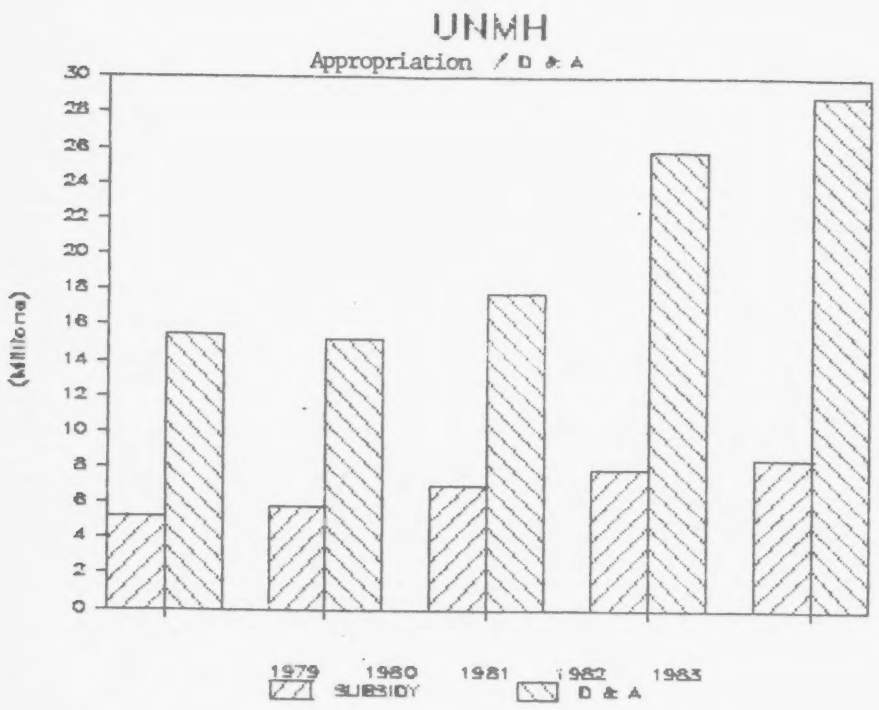
Slide 15


UNMH
INDIGENT REVENUES
('Millions)
11
10
9
8
7
6
5
4
3
2
1
0
1979
1980
1981
1982
1983

Slide 16


UNMH
OUT OF COUNT INDIGENT REVENUE
(Millions)
1.5
1.4
1.3
1.2
1.1
1
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
1980
1981
1982
1983

Slide 17


UNMH
Appropriation / D & A
(Millions)
30
28
26
24
22
20
18
16
14
12
10
8
6
4
2
0
1979
1980
1981
1982
1983
SUBSIDY
D & A

Slide 18

UNMH - OUR WORLD OF CHALLENGE

FACTORS INFLUENCING UNMH

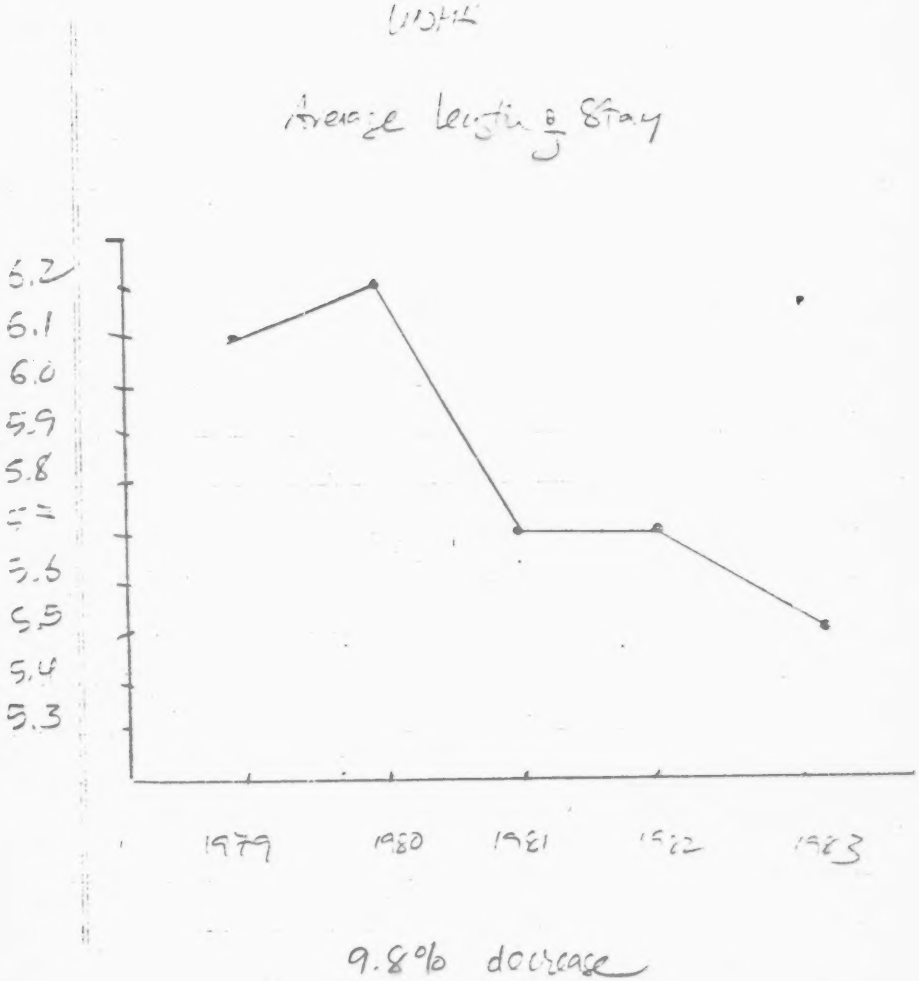
- SUNSET OF CERTIFICATE OF NEED LEGISLATION
- INCREASING DISCOUNTS AND ALLOWANCES
- FEDERAL PAYMENT
- COMPETITIVE MARKETING
- MILL LEVY CAMPAIGN - NOVEMBER 1984
- PARKING
- AMBULATORY CARE FACILITIES

Slide 19

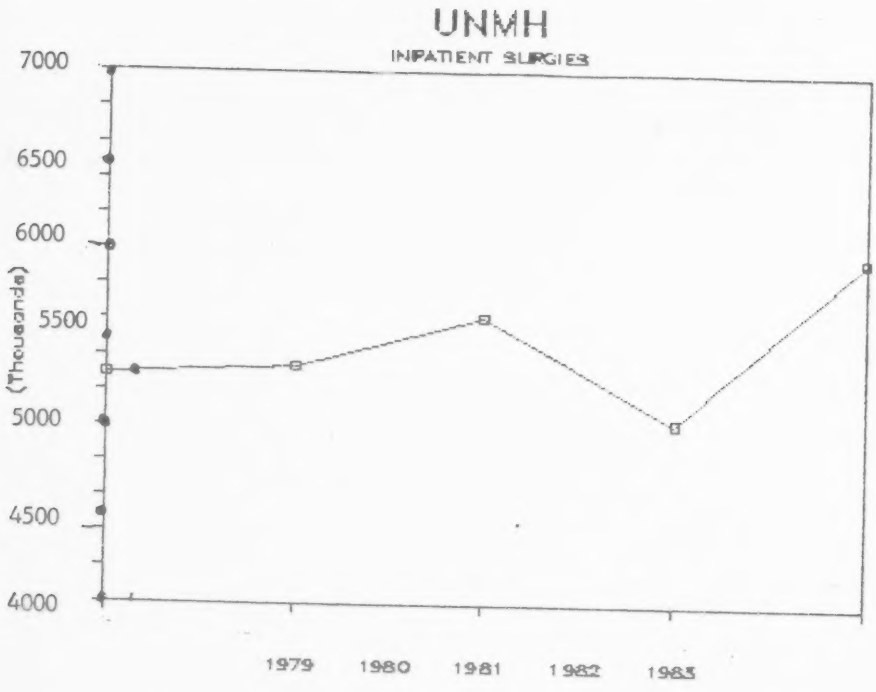
UNMH SURVIVAL

- MANAGEMENT--PHYSICIAN COOPERATION
  PHYSICIAN AND STAFF EDUCATION
- ENCHANCED DATA PROCESSING CAPABILITIES
- AGGRESSIVE PURCHASING PRACTICES
- JOINT VENTURES
- INCREASES IN MARKET SHARE
- IDENTIFYING UNMET MEDICAL NEEDS
- ALTERNATIVES TO HOSPITALIZATION
- EXPENSE CONTROL
- IMPROVE COMMUNITY IMAGE
- MEDICAL CENTER STRATEGIC PLAN
- CRITICAL CARE UNIT

Slide 20

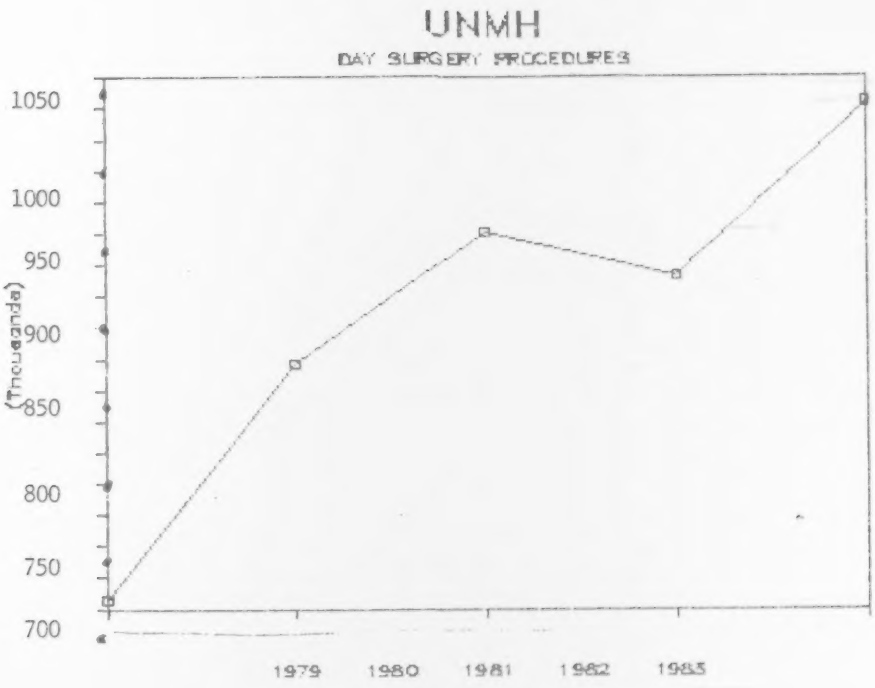

USHL
Average Length of Stay
6.2
6.1
6.0
5.9
5.8
5.7
5.6
5.5
5.4
5.3
1979
1980
1981
1982
1983
9.8% decrease

Slide 21



12.6% Increase

Slide 22



43.8% Increase

Slide 23

UNIVERSITY OF NEW MEXICO HOSPITAL

Medicare

UNFAVORABLE

Limits on Outliers

Inaccurate Medpar File

Admission Pattern Changes

Hospitals Enforcers of System

Limited Physician Controls

Cost Shifting Encouraged Or;
Dramatic Payment Changes
By All Payors

Reduced Hospital Services

Increased Hospital Costs Managing
Systems

32-906 O - 84 - 13

Slide 24

UNIVERSITY OF NEW MEXICO HOSPITAL

Medicare

FAVORABLE

Indirect Education Factor

Improved Cash Flow Management

Shift to Business Orientations

Understanding of Product Line Costs of Patient Care

More Incentive to Plan & Choose the Least Expensive Medical Options with the Same Quality

Outcomes

UNIVERSITY OF NEW MEXICO HOSPITAL
UNCOMPENSATED CARE
1983

	1983
Discounts & Allowances	$28,983,000
Contractual Allowances	
Medicare & Medicaid	$ 4,798,000
USPHS	$ 1,404,000
Insurance	$ 355,000
Other	$ 996,000
TOTAL CONTRACTUAL ALLOWANCES	$ 7,553,000
Discounts & Allowances Less Contractual Allowances	$21,430,000
Subsidy	
Mill Levy	$ 6,900,000
Neo-Natal	$ 432,000
Special Peri-Natal	$ 197,000
Out of County Indigent	$ 974,000
TOTAL SUBSIDY	$ 8,503,000
Uncompensated Care	$12,927,000

Senator DURENBERGER. I think I asked some of my more specific questions while you were going through the presentation.

Mr. JOHNSON. If I might interrupt? I had located some statistics relative to public hospitals, and employees, employed versus how long they were unemployed and you might at some time find that interesting to look at on the plane.

COMBINING LOCAL AND NATIONAL HEALTH CARE COMMITMENT

Senator DURENBERGER. Let me just explore with you a little bit, because it is starting to bother me now. It came up and it is bothering me a little bit more now, I guess. Let me preface what I have to say by saying that I occasionally disagree with my President and your Senator does, and we all do, because we think he needs as much help as anybody else. If we find ourselves in disagreement we have to let him know. One of the more disturbing things he said way back at the end of the year in 1981, when asked about the capacity of State and local government to pick up on things the Federal Government was doing, he is quoted as saying that people ought to be able to vote with their feet. That bothered me because there are a whole lot of Americans and others that can't vote with their feet.

That was particularly true during the recessionary hard times. It is also particularly true if you are depending on a family support system through rough times and so forth. So, philosophically I argue for a national response toward people. And yet that doesn't convert in my head to the fact that you have got to make everything a national program and nationally collected taxes and finance, which is one of our problems in that thing that for a long time got us into some of these problems that we have been talking about here all day. I guess what is bothering me is not seeing a lot of State and local involvement in financing the access of people to health care and/or, say, on the teaching side and so forth.

I know it is there and I know it probably has to compete with other things that go on in this State, but it strikes me that when you have got your choices among various things you are going to help folks out, health care is probably one of the more crucial. Preventive health is very important and so is acute health. But is there a way, without getting yourself into any trouble, to sort of characterize for a guy from out of State, who has to make some decisions for the whole country, how I can involve this local commitment along with a national commitment in getting this whole job done of making sure people don't have to move in order to have their needs met?

HOSPITAL SITUATION UNIQUE

Mr. JOHNSON. Senator, let me preface my comment that perhaps our situation is slightly unique. In the evolutional history of our institution, we began a formal affiliation with the State of New Mexico only in 1978. To that point we had begun as a hybrid Federal-county hospital, which evolved then into a county native American support hospital, and then into a State. And it is only within the last 5 years that the State has had a direct fiscal responsibility to the University of New Mexico Hospital. We began as the Berna-

lillo County Indian Hospital, then to Bernalillo County Medical Center, and in 1978 UNMH.

To that time Bernalillo County provided the support basically to indigents. And I think that one of the problems associated with the mill levy was, as everybody else, it is based on property assessed values. The recession came, and where we had a mill levy that was increasing at a 10-percent level, it dropped to 2 to 3 percent for about 2 to 3 years. That has been a problem. The State of New Mexico has tended to fund very generously those programs that have the greatest impact outside of Bernalillo County. We do about 30 percent of our business over a period of time.

As an example, a neonate intensive care unit. Approximately 3 percent of neonates come from outside of Bernalillo. That is very generously funded by the State and the out-of-county indigent fund. They have committed to a formula which will increase that at a reasonable rate over a period of time. So, circumstances here may be slightly different because of our evolutional goal. People are responding, not nearly as much as we would think.

The other situation is that the hospital is not in dire financial shape. We are not closing the doors. We are managing it, we think, in an effective way. No one is being turned away from our hospital, so we have avoided crises which frequently precipitate action.

Senator DURENBERGER. One last related question. I didn't see your whole financial statement, just the part on uncompensated and the subsidy. Not knowing much about it, if I looked at the figures, I would say you are qualified for chapter 11, chapter 13.

Mr. JOHNSON. No. We just believe that we manage our hospital very tightly, very fine tuned, and we have shown a small surplus over expenses for the past 4 years.

Senator DURENBERGER. Let me put it differently for the folks that come here out of Blue Cross, the Blue Shield, or Aetna or some other plan, how much of the costs we saw up there are they picking up?

Mr. JOHNSON. There is some substantial crossover, yes.

Senator DURENBERGER. Ten percent, 20 percent, 30 percent, 40 percent?

Mr. JOHNSON. I don't have that spec.

Senator DURENBERGER. This isn't just New Mexico. This is happening all over.

Mr. JOHNSON. And I tried to show that with that slide, sir.

Chairman DOMENICI. The 21 to 17 slide?

Mr. JOHNSON. Yes.

Chairman DOMENICI. Somebody wanted them both to be 17.

Mr Johnson. Yes.

DEGREE INDIGENT LOAD DECREASED BY MEDICAID

Chairman DOMENICI. Do you have numbers available as to how much of the indigent load would be replaced by medicaid if we had the medicaid coverage alluded to this morning that we don't have?

Mr. JOHNSON. At this time, Senator, we take about 25 percent of the hospital medicaid funds in the State of New Mexico, and, as I think Mr. Shaver said, we are beginning to explore this and we are putting together first a data system within the hospital association

to try and find out what all these numbers would mean, and the hospital is trying to generate that kind of data at this time, simulating what would happen if different programs were effected.

COVERAGE UNDER MEDICAID NOT BEING USED

Chairman DOMENICI. It seems to me that before lunch we were being told that there is probably significant coverage under medicaid that was not being used. I was told it was a 70–30 option. I thought I was beginning to understand that that might pick up a substantial portion of the indigent load. But then I saw your slide up here on 100 largest city public hospitals, and I imagine they are all over the country.

Mr. JOHNSON. Yes, sir.

Chairman DOMENICI. I imagine many of those are in States that have that medicaid coverage, that huge percent of indigents, still there. So am I missing something?

Mr. JOHNSON. I think that if you look at the data on the 100 largest public hospitals, they are spending 22 percent of their resources. That doesn't necessarily mean that they are getting some reimbursement for that. You look at the University of Utah on which you had commented, and there is a whole different attitude in terms of bad debt. There is none in that institution.

Senator DURENBERGER. Called LDS up there.

Mr. JOHNSON. John Peter Smith Hospital in Tarrant County, Fort Worth, they are putting in over $20 million a year to support the indigent program. Therefore they don't have that financial stress that many other hospitals have. It is a commitment within the community of what you are going to do. The difficulty with our type of hospital, which I think the doctor talked to you about, is research. We have a research mission. The funds available for education, medical education, the teaching, et cetera, are not growing. And we have a situation where we have a patient mix that is not the most favorable in the country.

POOL INDIGENT FUNDS STATEWIDE

Is Howard still here? Howard, your comments were directed to the medical needy program, weren't they? What I alluded to is the counties that do have a medical indigent fund or medical needy fund, these have never been combined or pooled into a statewide formalized program. Therefore, they do not qualify for matching and the memorial being recommended from the Senate is for the State to look at how these various programs are managed and how they in fact can be collected into a centralized medical needy program and get the multiplier, $6.9 million. In Bernalillo, if you multiplied that on a 3:1 basis, we are talking about $21 million. That becomes significant. Santa Fe County is a million and a half. We are looking at a substantial multiplier back.

But that doesn't make your problems easier as you try to manage the Federal Government budget.

Chairman DOMENICI. No; it doesn't. But you see it does mean that if we are moving nationally with an assumed set of facts that yield a national problem and ours is different than that, because of this failure, then as they solve it in their community we are going

to have not only bad things, we are going to have this place maybe in chapter 11 for real instead of assumed. Because they are not going to take that into account. We may solve the national one and we have to surely be in a similar posture where we are taking advantage, as most States apparently are, of that match. It would be a pretty big chunk of money. Are there other medicaid coverages that apply to hospitals that we are not opting to take advantage of? Howard has a statement.

INDIGENT PROGRAM HAS ADVANTAGES OVER MEDICAID

Mr. SHAVER. The medical indigent program is the only one we are not really taking advantage of at this time. The nice thing about the program is you don't have to offer all the services that the regular medicaid program offers. You can target them to catastrophic needs that end up in the UNM Hospital and other places.

Chairman DOMENICI. But the study that you referred to is not only going to evaluate the present contribution that might be put in a pot and get matched, I assume it is going to measure the entire qualifying need in New Mexico that could be matched 30 percent New Mexico, 70 percent Federal; is that correct?

Mr. SHAVER. Yes; as well as design the program, as well as decide where the targets ought to be directed. It is a pretty comprehensive study.

Chairman DOMENICI. And if we can get along until then, that may be one that we have to sell locally to get around the indigent problems as these other programs have their marketplace effect; is that right?

Mr. JOHNSON. Yes; in Bernalillo County the 6.9-mill levy is not designated indigent. It is for the operation and maintenance of the county hospital. It has loosely been interpreted to cover indigent care.

Chairman DOMENICI. And in terms of that portion of this institution which is doctor training, you put that up there and you listed it as one of them. How do we quantify it in formularization nationally?

Mr. JOHNSON. I receive credit for that under the medicaid cost report. The direct salary costs are a passthrough under the medicaid cost report. Under the new prospective payment, I will receive a bonus in the indirect education, of costs for teaching care. At this time, that is a favorable compensation for severity problems.

Chairman DOMENICI. That is coming out all right?

Mr. JOHNSON. Yes, sir, always I said. It is outside the system and it is clearly vulnerable.

Senator DURENBERGER. And it will only last 2 years. Thank you very much. I think it is an excellent presentation. I appreciate it.

Mr. JOHNSON. Thank you, sir. We are glad to have you.

Chairman DOMENICI. Ms. Crenshaw, we are delighted to have you.

STATEMENT OF VIRGINIA CRENSHAW, ALBUQUERQUE, N. MEX.

Ms. CRENSHAW. Thank you. Good afternoon, Senator Domenici. Thank you for including time for the elderly in this hearing, for the elderly are consumers. I want to start by saying some good

things about medicare. The fact that it is in operation is good. It is a great help, as far as it goes.

I acknowledge recent changes to cover hospice care and the system to pay by DRG, but there are some problems. In the first instance: Hospice—it is not always the exact time allowed; 6 months can't be exact. And also on hospice, having sig away the rights to acute care, the patient may need to go into hospital for acute care, but with no coverage.

About DRG, I think it is a very good idea, but elderly people have multiple diagnoses, not just one that has a set period of time. I have not seen the regulations, but I do assume that multiple diagnoses and complications are considered. I am a healthy and active age 71. I can expect to have several years, maybe 10, 15, of slowing productivity and slowing activity, then frailties increase and I really go downhill. I have signed a living will but in New Mexico, so far that has protected only the doctor. He would not have to respect my wishes if he did not want to.

I have worked hard all my life and absolutely deplore the "gimme, gimme" attitude of some people. Too often consumers cry out from one parochial point of view. I have a modest retirement and resources for a decent living, but chances are, as frailties increase, if things don't change, I will go downhill and have multiple illnesses. If some of the medical industry has its way, they will argue with God to sustain life processes using expensive equipment and more tests and maintenance treatment, flying in the face of indignities of deterioration and hopeless pain and neglect. I do hope that DRG changes this trend.

But they could use up my assets and my savings with no thought for humaneness nor for conservation of resources. There seems to be a cultural attitude among some people that when I have outlived my savings and my funds are depleted, a deficit-ridden Government will pay by medicaid. They might put me away in a warehouse run for profit, where they put dilapidated bodies. There I would be fed not enough, and washed not often enough, by unskilled labor. I have heard how Eskimos put old folks out on the ice. Here in a civilized wealthy society we have tended to put old folks away to sit in a stupor in front of the TV.

Now, I am not here to play the game of "ain't it awful," but to point out that this is exactly what many elderly persons think. They live with this fear day and night. And, also, I hasten to say, that I am absolutely sure that in New Mexico we have better than average nursing homes and we have some loving, caring persons running them. Some of my best friends, and most admired professionals, are working in nursing homes doing what they can to change the pattern.

COST CONTAINMENT

Well, why bring up all this horrible situation? I find myself in the uncomfortable position, or maybe comfortable, of representing consumers today, following a long list of excellent providers this morning and this afternoon. In the payment process, it seems to some of us consumers, that providers and consumers are practically in adversarial positions and I don't like that. To depend solely

on providers for cost containment is—and I am sure you heard it before—is like putting the fox in charge of the chicken house.

PROVIDERS AND CONSUMERS TO STUDY PROBLEMS

I am outspoken to voice my views against adversarial positions. We need the best possible minds—providers and consumers—to work together toward cost containment. This brings me to my first point: I recommend that groups and councils working on problems of medicare be made up of a reasonable mix of providers and consumers to work together as a team, and that those superior minds be able to get a grasp of the problem.

I wanted to be here this morning to hear what "they" had to say and to listen with concern. Of course, each speaks from his own frame of reference. And each has his own frame of expertise. Let us face it. It is "they" providers and "we" consumers and, of course, doctors, hospitals, and nursing homes and insurors want to do the best they can, but that is one-sided power.

I think it is a mistake to put too much of the cost containment efforts on the backs of the consumers. Now I understand that a council has recently recommended to increase the age of medicare from 65 to 67, which means that we would be forced to either work 2 more years or, for many, be without medical insurance for those 2 years. And to add to the premiums the deductibles and copayments and cut benefits puts too much burden on the consumers.

How shall we, providers, decisionmakers, and consumers, work together on the problem? I want a civilized, straightforward approach, sort of like we have today. I do not know how that could come about. So much of the literature that we read is very exaggerated on one side or the other. I hate to say that we need a law. How would Congress mandate that the "they's" and "we's" work together? You in Washington have ways to exert pressure. One suggestion, of course, comes to mind which is tax incentives. I know that is not simple, so I leave the actual implementation to the higher ups. That was my first recommendation, that groups working on the problem be made up of a mix along with the providers and consumers, with a high degree of intelligence.

HELP NEEDED TO UNDERSTAND MEDICAL BILLS

My second recommendation is that helpers would be provided to assist the patients and their families read their medical bills. As I understand it, medical and hospital bills do not need to be itemized, but it is possible to request an itemized bill. And when they do request it and get it it just blows their minds. Of course I realize bookkeeping is complex and everything is computerized. That is the way it has to be. But we poor souls, just plain consumers, are at a loss to read yards and yards of computer printout.

When a person has been sick and in the hospital, even if he gets better he is really too sick to cope with a complicated bill. Even if he is not that sick he is incapacitated from just the hospital experience. And, likewise, his family is preoccupied with the illness experience. We certainly cannot afford to hire an accountant to read it but helpers are available for income tax returns and I would like to see them available for the medical service business.

I heard last week of a situation where the middle-aged daughter found an error in her elderly mother's bill but her mother would not let her question it "Oh, no. They will put us down as complainers and won't be nice to us the next time." She felt sincerely that she should not question the powers that be.

HELP NEEDS TO UNDERSTAND THE SYSTEM

My third recommendation is to have troubleshooters available for the average and below average in energy to hassle the system. This is not the same as reading the bill. And I will skip the two examples that I have in here of people who have spent from March 1982, and the other from December 1981, going through series of denials and appeals, denials and appeals.

In one instance the appeals went before the administrative law judge and finally got an approval. And when there is a mistake in the computer, it is impossible for us to bird dog it and see where things have been kicked out. No civilized country should put a human being through that much torture. And usually these are the spouses that are left after a loved one has been dying for maybe 2 years.

EMPHASIS ON HOME CARE GOOD IDEA

My fourth recommendation is to look at what is covered and what is not covered and revise the list in the light of the best long-term benefits. By benefits, I mean least expensive personnel and least restrictive setting, such as more use of nurse practitioners, nurse's assistants, and homemakers. The least restrictive setting would be home care. And I am very glad that we have heard so much about that today.

I realize that not all aspects of medical service can be covered. There is just not enough money in the world to go around. But the maintenance service that is making it possible for individuals to live at home and stay out of the expensive institution must be seriously considered. I will skip the examples. I have one about maintenance, one about mental illness, one about the process of healing, rather than being healed, and the other would be the limits on medications.

For example, medications at home are not allowable. The day before yesterday a nurse told me that it is not uncommon for a patient to be at home, following hospitalization, with 15 medicines ordered by the doctor. And the patient will say, "I have money for only three. Which three shall I take?" The nurse will call the doctor and ask which three shall it be. We must have more containment placed on providers.

Medical service is an industry, but a sick person cannot shop around. If I buy a dress or a car, I can certainly shop around and select what I like and what I can afford. When I am sick, I am in no condition to shop around and select what I want and what I can afford.

Senator Durenberger, I plan to find out more about the voucher system which you mentioned.

MORE PHYSICIANS IN RURAL AREAS AND SET FEES

My fifth recommendation is that physicians be encouraged by incentives to practice in underserved rural areas and also to accept reimbursable amounts set by the medicare as payment in full for medicare patients. And, again, Senator Durenberger, you mentioned this morning that doctors are making house calls and are being available on weekends. I am not hearing about doctors moving into rural areas, but something could be worked out as a system to cover that area. I say this because I can't expect them to do it voluntarily. I am sure that incentives can be figured out including tax incentives.

In closing, about the impact in New Mexico, my impression, and I have been told very distinctly that consumers—patients, and sooner or later we will all be patients—we don't know what it is all about. We are confused and we are scared. And those are other people's words; but I agree. Confused and scared. Some are angry at having to expend too much energy and struggling with the system, contending and coping with business and payments, and with denials after denials and appeals after appeals. I hate to see our Government and our medical service industry treating old people this way. A spouse watching a loved one suffering and dying should not—must not—go through some of the horror stories that we are hearing. It is a shame on our society.

Thank you for this opportunity to express myself and speak for the elderly. They cannot speak here for themselves.

Chairman DOMENICI. Serafin, we are delighted to have you here. And I understand that Ms. Maes cannot be here. Will you please proceed?

STATEMENT OF SERAFIN VIGIL, IN BEHALF OF RITA MAES, DIRECTOR, DIVISION OF SENIOR SERVICES, CITY AND COUNTY OF SANTA FE, N. MEX.

Mr. VIGIL. Honorable Senators, thank you for allowing me to participate on a panel discussion on medicare reform. I have read recent changes in medicare regulations that presumably are supposed to curb medical cost and possible abuse by hospitals and medical practitioners. However, at this early stage I have not been able to evaluate the impact of the reform of making payments on a diagnosis rather than hospital costs. It is still unclear to me how increases unrelated to the diagnosis are covered by medicare.

The case in point that I think of is the using of dialysis to care for renal diseases. If that renal disease is attributed to diabetes that the individual had or carried on for 10 or 15 years prior to that, is it going to be a diagnosis of diabetes or is it going to be a diagnosis under renal infection?

Once the medicare reform is fully implemented, I am speaking only of Santa Fe, our office will conduct a study locally on the effectiveness of the program for your review and your information.

SOCIAL SECURITY RECIPIENTS CAN'T AFFORD MEDICAL CARE

On other medicare issues, it should be emphasized that of the 106,365 New Mexicans on social security, 99 percent are on medi-

care. Of this figure, over 10,000 individuals live on social security benefits alone. The average social security check in New Mexico is $304 per month. With the high cost of medical care, it has become impossible for many elderly to afford medical attention. I would also like to address the group between 60 and 65. I have been notified that this group neglect health care due to no health insurance and ineligibility for medicare. I have been with the senior program in Santa Fe for the past 7 years. And I have seen the individuals over 65 years of age who are under medicare not able to pay the 20 percent or the deductible.

They have said: "My doctor tells me to go to the hospital, but I can't afford to pay the deductible or the 20 percent." I have referred them and try to encourage them to go for assistance from the county indigent fund. And by and large most of them say: "No way, Jose. Because I don't and I never have asked them and I don't intend to start now."

LOWER ELIGIBILITY FOR MEDICARE

Now, by the same token, with the 60 and 65, this is a group that allows their health to deteriorate, because they can't afford it. I would recommend that the eligibility for medicare be lowered to 60 or 62. Granted, the medicare program has served many New Mexicans who were fortunate to have supplemental insurance and meet the 20 percent of the costs and the deductibles. However, most New Mexicans, cannot afford suppiemental insurance and can barely meet the medicare premiums.

Senators, it is imperative that a good program like medicare—as Ms. Crenshaw stated, it is a good program—remain reachable to the poor elderly. With limited increases in social security benefits, and proposed increases in part B payment of medicare, it is likely that a percentage of the elderly would no longer be able to continue the health program. As an example of the problems facing the elderly and handicapped population in New Mexico, I interviewed Gretchen Terry, a medicaid-medicare recipient.

Ms. Terry is 49 years old and resides in a Santa Fe low-income housing unit for the elderly and handicapped. She is suffering osteoarthritis of her spine which has caused a series of problems, including lockjaw, severe headaches, neck stiffness, and is now beginning to suffer loss of her left hand. Her dental costs, for jaw alinement, were $825.09 of which medicaid paid only $79 plus tax. Neither medicare nor medicaid accepted bills for physical therapy for Ms. Terry's treatment. Ms. Terry's health becomes an ever-increasing problem, and she may now have to undergo neurosurgery for her left arm and shoulder.

Proper nutrition is also a problem for Ms. Terry, as inflation has prevented her from preparing an adequate diet. Eye care is also expensive. Medicaid only paid $25 on glasses which cost Ms. Terry $200. Now, that was 2 years ago. Ms. Terry is only one New Mexican facing a multitude of problems. While social agencies have coordinated to alleviate her health cost, the burden of mere subsistence is inevitable.

HEALTH MAINTENANCE ORGANIZATIONS

Senators, the stress and worry on the elderly and handicapped of this Nation is now at an all-time high. As I have heard this morning and as I stated to Senator Durenberger and Senator Domenici's staff in Santa Fe, there is a proposal that maintenance organizations be developed in Santa Fe, and I look at that.

Recent changes in medicare regulations may encourage more and more older Americans to join health maintenance organizations. Now these health organizations are the ones in Florida and that has extended up into Minnesota and the northeast. These organizations provide individuals with medicare parts A and B with free doctors visits, free prescriptions, free hospitalization, free eyeglasses, free hearing aids, free routine dental care. Please see the attached forms that are with this thing.

And I would recommend that an HMO for medicare recipients in New Mexico would eliminate many of the problems such as Gretchen Terry's problems have been, and would put greater emphasis on keeping patients healthy rather than merely treating them when they are ill. Thank you very much, gentlemen.

Chairman DOMENICI. Thank you, Mr. Vigil.

[The full prepared statement, with attachments, of Rita Maes follows:]

Statement of Rita B. Maes, Director, Division of Senior Services, City and County of Santa Fe, N. Mex., Presented by Serafin Vigil

Thank you for allowing me to participate on a panel discussion on medicare reform.

Recent changes in medicare regulations has helped to curbe medical costs and possible abuse by hospitals and medical practitioners. However, at this early stage I have not been able to evaluate the impact on the reform of making payments on the diagnosis rather than hospital costs. It is still unclear to me how illnesses, unrelated to the diagnosis are covered by medicare. Once the medicare reform is fully implemented, my office will conduct a study locally on the effectiveness of the program for your review and information.

On other medicare issues, it should be emphasized that the 106,365 New Mexicans on Social Security, 99% are on medicare; of this figure, over 10,000 individuals live on social security benefits alone. The average social security check in New Mexico is $340.00 per month. With the high cost of medical care, it has become impossible for many elderly to afford medical attention. I would also like to address the age group between 60 and 65. I have noticed that this group neglect health care due to no health insurance and ineligibility to medicare. The Senior Citizens in this age group allow their health to deteriorate. I would recommend that the eligibility for medicare be lowered to age 62.

The medicare program has served many New Mexicans who were fortunate to have supplemental insurance and meet 20% of costs and deductibles. However, most New Mexicans cannot afford supplemental insurance and can barely meet medicare premiums. Senators, it is imperative that a good program like medicare remain reachable to the poor elderly. With limited increases in Social Security benefits, and proposed increases in Part B payment of medicare, it is likely that a percentage of the elderly would no longer be able to continue this health program. As an example of the problems facing the elderly and handicapped population, I interviewed Gretchen Terry a medicaid, medicare recipient. Ms. Terry is 49 years old and resides in a Santa Fe low income housing unit for the elderly and handicapped. Ms. Terry subsists on a monthly benefit of $334.60 per month. She is a victim of osteo arthritis in her spine which has caused a series of problems, including lock jaw, severe head aches, neck stiffness and is now beginning to suffer loss of her left hand. Her dental costs, for jaw alignment was $825.09 of which medicaid paid $79.00 plus tax. Neither medicaid or medicare accepted bills for physical therapy for Ms. Terry's treatment. Ms. Terry's health becomes an ever increasing problem, and may now have to undergo neuro surgery on her left arm and shoulder. Proper nutrition is also a problem for Ms. Terry, as inflation has prevented her from preparing an adequate diet. Eye care is also expensive and medicaid paid only $25.00 on eye glasses which cost Ms. Terry $200.00, two years ago. Ms. Terry is only one New Mexican facing a multitude of problems. While social agencies have coordinated to alliviate her health costs.

the burden of mere subsistence is inevitable.

Senators Domenici and Durenburger, the stress and worry on the elderly and handicapped of this nation is now at an all time high. A proposed Health Maintenance Organization for New Mexicans may be an appropriate solution for affordable health care.

Recent changes in medicare regulations may encourage more and more older americans to join a Health Maintenance Organization. The Florida Health Maintenance Organization is federally qualified and provides individuals with medicare Parts A and B with:

Free doctors visits
Free precriptions and specific pharmacies
Free hospitalization
Free eye glasses
Free hearing aides
Free routine dental care

(Please see attached for more information on Health Maintenance Organization).

An HMO for medicare recipients in New Mexico would eliminate many of the problems such as Gretchen Terry's, and would put great emphasis on keeping patients healthy rather than merely treating them when they are ill.

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International Medical Centers HMO

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"When IMC asked me to talk to you, I first talked to them."

Before I agreed to endorse the Gold Plus Plan, the International Medical Centers No-Premium Medicare Plan with free benefits, I wanted to know about the quality of care you'd receive.

I had to know that the Gold Plus Plan would be better, and offer you more, than your current Medicare supplemental coverage. That an IMC Health Center would be close to your home, and easy for you to get to. That you would be able to choose your own personal doctor. That hospitals would accept you as an IMC Medicare patient as they would any other Medicare patient. That there are meaningful and important advantages to the Gold Plus Plan over ordinary add-on insurance.

I asked every question I thought *you'd* ask. And IMC convinced me that the Gold Plus Plan makes Medicare the best it can be for you. That's why I agreed to speak for them and why I'd like to tell you now just how the Gold Plus Plan benefits you.

With the Gold Plus Plan, you'll get extraordinary free benefits.

With the IMC Gold Plus Plan, for individuals with Medicare parts A and B you get:

- Free doctor's visits
- Free prescriptions at any Eckerds, Walgreens, and other fine pharmacies
- Free hospitalization
- Free eyeglasses
- Free hearing aids
- Free routine dental care

The Gold Plus Plan provides you with many benefits that people on Medicare need, at no cost. That's important. And it's even more important for people living on a fixed income. Your savings should go towards making your retirement the best and happiest years of your life, not towards high medical bills that the Gold Plus Plan could pay for you.

Look closely at the comparison benefits chart in this brochure. You'll see for yourself how much more health care you receive with Gold Plus as opposed to your present plan.

Our priority is preserving your health.

When you reach 65 and older, or otherwise become Medicare entitled, you deserve the best of everything, especially the best of health. International Medical Centers under contract with the U.S. Government is working to help you preserve it. At this point in your life, you deserve the best medical care you can possibly receive. You deserve to be free of worries about high medical bills wiping out your savings. You deserve to enjoy the best years of your life in the best health possible. Under contract with the U.S. Government, IMC

makes Medicare the best it can be, for you, for free.

Very simply, the IMC Gold Plus Plan becomes your partner in health care.

And it's undoubtedly one of the best partners you can have. Under a special contract with the United States Government, IMC is the largest HMO Medicare plan in the State of Florida. And our Gold Plus Plan is one of the fastest growing HMO Medicare Programs in the entire United States.

To you, this means that IMC will deliver the kind of quality care you deserve whenever you need it. Today and years to come.

With over 50 Health Centers in Dade and Broward Counties* IMC is growing stronger every day.

Take a look at our Health Center locations on the back page. There's probably an IMC Health Center near you right now. That becomes your doctor's office. It also becomes your personal Health Center, an environment staffed with caring professionals and outfitted with the latest innovations in medical technology and equipment. In short, your IMC Health Center is one of the best places you can go to receive medical care anywhere in Dade and Broward Counties. It's where we want you to go for care as often as you need to. And any time you're unable to provide your own transportation to the Health Center for medical appointments, IMC will provide free transportation for you.

*We are planning to expand our service to Palm Beach County in early 1984.

You can choose your own personal doctor from many highly-skilled IMC physicians.

Naturally you'd like you own doctor to care for you. Someone who knows you, and is familiar with all your health care needs. And you can choose your personal physician from highly qualified IMC physicians in many specialties. Just remember to receive all your health care from IMC except for emergency or urgently needed service.

You'll be accepted at every hospital that accepts Medicare.

With IMC you do not give up your Medicare coverage. So if you ever need to be hospitalized, for any reason, you'll be accepted as an IMC patient as would any other Medicare patient. Which means that if you ever require emergency or urgently needed health care, you're covered even outside of IMC's service area.

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Why not take a few moments right now to fill out your application and mail it. You'll be joining over 25,000 Floridians who are receiving the finest health care and the many free benefits they deserve.

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OSPITAL INPATIENT	You pay hospital deductible and additional charges after 60th day	NO CHARGE Unlimited days.
OSPITAL OUTPATIENT	You pay deductible and 20% of charges	NO CHARGE
MBULANCE, EMERGENCY SERVICES	You pay $75.00 deductible and 20% of charges	NO CHARGE
RUGS THAT REQUIRE DOCTOR'S RESCRIPTION	You pay 100% of charges	NO CHARGE
OUTINE DENTAL SERVICES	You pay 100% of charges	NO CHARGE for comprehensive benefits.*
YE REFRACTIONS AND GLASSES	You pay 100% of charges	NO CHARGE, including 2 pairs of glasses each year.
EARING AIDS	You pay 100% of charges	NO CHARGE, including one hearing aid every 3 years, after 6 months of continuous membership.
OUTINE PODIATRY	You pay 100% of charges	NO CHARGE
OUTINE PHYSICAL EXAMS, OUTINE IMMUNIZATIONS	You pay 100% of charges	NO CHARGE
PATIENT PSYCHIATRIC CARE	You pay 50% deductible and 50% of charges; limited to $350 per year	NO CHARGE
PATIENT PSYCHIATRIC OSPITAL CARE	You pay deductible and 20% of charges	NO CHARGE up to 190 days per lifetime.
ILLED NURSING FACILITY	You pay deductible and 20% of charges after 3 day hospital stay	NO CHARGE up to 100 days. No hospital stay required.
OME HEALTH CARE	You pay 20% of charges to Medicare limits	NO CHARGE to Medicare service limits.
RANSPORTATION TO AND FROM EALTH CENTER	You pay 100% of charges	NO CHARGE when medically necessary.
DDITIONAL BENEFITS: x-rays, b tests and special diagnostic ocedures, physical therapy, durable edical equipment, prosthetic vices, blood, dressings, casts, edical supplies, speech therapy, health ducation and medical social services.	You pay 20% of charges after $100 annual deductible	NO CHARGE

EDICARE EXCLUSIONS:

- ...le examinations for ...
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- ...metic purposes, ...
- ...al comfort items ...
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- ...procedures, transplants and ...
- ...fessional charges in Medicare ...

IC EXCLUSIONS:

- ...Medicare exclusions; non-emergency ... Medicare will not pay when not medically necessary

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...ditional benefits to this brochure at a later date

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Name _____

Address _____

Sex _____ Marital Status _____

Date of Birth _____

Do you have any other health insurance? ___ Yes ___ No

If yes: Name of Company _____

Policy No. _____

EMERGENCY CONTACT DATA (Name of nearest relative not living with you)

Name _____

Address _____

Yes, I wish to enroll in

☐ **THE GOLD PLUS PLAN**

I wish to receive my monthly newsletter in: ___ English ___ Spanish

PLEASE CHECK AND SIGN BELOW

___ I am currently enrolled in Parts A and B of the Medicare Program.

___ I am currently enrolled in Part B only of the Medicare Program.

___ I am enrolled in Medicare Part B and Med-Cal. Medicaid No. (if applicable) _____

I hereby authorize the Health Care Financing Administration to furnish information to International Medical Centers, HMO, affirming my entitlement to Hospital Insurance Benefits (Part "A") and enrollment for Supplementary Medical Insurance Benefits (Part "B") under Title XVIII of the Social Security Act and to furnish the Plan information as to: Part A and Part B benefits recorded, records, or other information services not furnished by or through International Medical Centers, HMO, and should my enrollment be terminated, the effective date of such termination. It is understood that information obtained in connection with the operation of this plan I also authorize International Medical Centers, HMO, or any other individual or entity that may have information to disclose to the Health Care Financing Administration or its intermediary or carrier any information needed to administer [illegible] of the Social Security Act.

I also understand that I am enrolling in a demonstration project and upon termination of the demonstration project for the expiration of the project, my previous status and entitlement under the general Medicare program will not be affected by my participation in the demonstration project.

It is my understanding that all my medical services, except in case of emergency anywhere or urgently needed services while temporarily outside IMC's service area must be provided or arranged for by IMC. Services rendered, without consent of IMC, except in an emergency anywhere, or when care is urgently needed while outside IMC's service area, will not be reimbursed by IMC or Medicare.

X _____ _____
Applicant's Signature Date

X _____ _____
Enrollment Coordinator Center No.

DO NOT WRITE BELOW THIS LINE

Group No. ☐☐☐ Member No. ☐☐☐☐☐ Coverage ☐ Effective Date ☐☐ ☐☐ ☐☐
Mo. Day Yr.

MKN

Questions and Answers

Q Is everyone eligible for Medicare eligible for the Gold Plus Plan? What if I have a pre-existing health problem?

A Everyone with Medicare Parts A and B, with the exception of people with end-stage renal disease, is eligible to join the IMC Gold Plus Plan. Members with only Part B coverage should contact IMC for information regarding their benefits. There are no exclusions for pre-existing conditions, and no claim forms to fill out. The IMC Gold Plus Plan covers all benefits described here, while providing access to virtually all medical care.

Q What happens if I join and later change my mind? Will I lose my Medicare benefits?

A No. A Medicare beneficiary may disenroll from IMC at any time by submitting a signed, dated request on forms provided by IMC. It takes no more than 6 weeks, and usually less, to make disenrollment effective.

And should you disenroll, you will be automatically reinstated in the regular Medicare program.

Q Will I have my own doctor, and how qualified is he?

A IMC means personalized care. You select your primary physician from one of the specialists in General Practice or Internal Medicine participating in the IMC plan. Your IMC primary physician supervises your health care at one of IMC's 24 convenient locations, and in the hospital and arranges for any specialist services, as necessary.

Q Can I lose my Gold Plus coverage?

A IMC may disenroll a Medicare beneficiary for any of the following reasons: fraudulent statement on the application form; loss of Medicare Part B coverage; voluntary disenrollment; failure to use ID card to obtain services from IMC Gold Plus; you will be automatically disenrolled from IMC when you enter the Medicare program.

Q If I go outside IMC for services, will IMC still pay for it?

A In the event of a medical emergency or urgently needed services outside the service area, you should notify IMC as soon as reasonably possible. Medicare, through its own fiscal intermediary, will also pay for emergency services provided outside the service area. Non-emergency services received outside IMC is the responsibility of Medicare.

Q What are emergency urgently needed services?

A A medical emergency is a medical or psychiatric nature that, if not treated immediately, could result in death, severe pain, or permanent health problems. Urgently needed services are those for illness, which are not life-threatening, but require prompt medical attention that cannot be wholly provided while you can get to your regular source of your health care.

Q What if I have an emergency?

A In the event of a medical emergency, 24 hours a day, 7 days a week, you should call your doctor first. If you cannot reach your doctor, go to the nearest emergency room. Be sure to notify the hospital or other emergency facility that you are an IMC HMO member.

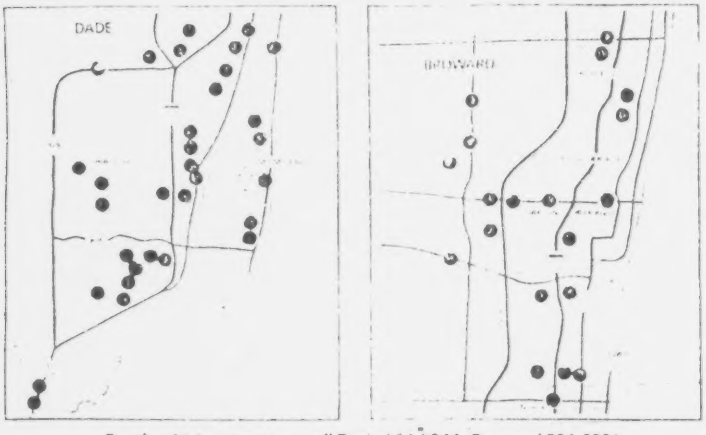
Q What if I require urgently needed services?

A Urgently needed services are those for which IMC will authorize payment. Before you receive urgently needed services, you should contact IMC to determine if the cost of the service will be covered by IMC or Medicare.

Q If I have a complaint, will somebody listen?

A IMC has a staff dedicated to assisting you with any questions or problems you may have. Toll-free telephone numbers are provided for your convenience. Should you have a complaint, you will receive a written response within 30 days of receipt of this complaint. Appeals from IMC decisions are handled in the regular Medicare program.

Over 50 medical facilities to serve you.



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Miami 2
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Miami, Florida 33135

North Miami
9475 N.W. 2nd Avenue
Miami, Florida 33169

Hialeah
2900 Palm Avenue
Hialeah, Florida 33012

Miami Beach
1001 Lincoln Road Mall
Miami Beach, Florida 33139

Westchester
8988 S.W. 40th Street
Miami, Florida 33165

Edison - Little River
178 N.W. 54th Street
Miami, Florida 33150

Hollywood
2028 Hollywood Blvd.
Hollywood, Florida 33020

January 12, 1984

Ms. Rita B. Maes, Director
Division of Senior Services
P.O. Box 909
Santa Fe, New Mexico 87501

Dear Ms. Maes:

Thank you for your letter of December 5, 1983. Enclosed please find a Gold Plus Plan Brochure, please feel free to share it with your membership.

I suggest that you obtain the Adjusted Area Per Capita Cost for Medicare beneficiaries in your county. We might be interested in coming to your area with our plan if the demographics (over 65 population) and the AAPCC are reasonable, and if your organization gives us their support.

If we can be of further assistance, please let me know.

Sincerely,

Júlio A. Avello

Júlio A. Avello, Ph.D.
Vice President For
Corporate Development

JAA/ev
Enclosure

cc: Noel Marshall
John Ward, Esquire

Chairman DOMENICI. Do you have any questions, Senator?

CATASTROPHIC ILLNESS INSURANCE

Senator DURENBERGER. I was looking through this material on the international medical centers. I can't find the price anyplace. Thank you very much for providing me this information. As I told you earlier, I will follow up. I want to ask a question of both of you, I guess, about catastrophic insurance. Somehow I have gotten the impression from talking to my parents, who are now 72 and 77, and they are spending a lot of money for supplemental insurance, I think they are paying $55, $58 a month, each of them, to supplement their current medicare program.

And when they saw these vouchers being advertised in Minneapolis and St. Paul, $19 and some cents, they called me up and probably had the same questions I had when I looked at the international medical. I found, obviously, in time, in talking to my parents, their deepest concern is what happens if I am in there a long time, or terminal illness, or as we heard earlier, those last 60 days? We don't have the catastrophic benefit in medicare today.

Does it strike you a little strange that in our desire to adequately provide for elderly Americans that we never put a thing that looks like they would need most into medicare? What should we do about that? Have you both got catastrophic coverage and did you buy it?

Mr. VIGIL. I have supplemental insurance.

Senator DURENBERGER. Do you get the catastrophic feature?

Mr. VIGIL. It is a nonlimited thing. I pay through the nose for it.

Ms. CRENSHAW. I kept it from where I was employed. When I retired I was able to continue on with that supplemental. I don't know. I am so healthy that I really haven't used it and I haven't faced a lot of these questions that I do know are down the road and are imminent for many people.

Mr. VIGIL. I have some more information on this international HMO. My understanding from them is that medicare in their contract provides $300 a year for each recipient. Now, if they have 25,000 Floridians at $300 per head——

Senator DURENBERGER. The thing that is puzzling me is that we have authorized an expansion of the medicare voucher option so that you could take an entitlement and go buy a private plan with it. But the regulations aren't out yet on it and I would be surprised if this is what it was. And I guess together we will investigate it and find out what is going on.

Mr. VIGIL. I would appreciate as much information on this as I can get.

Chairman DOMENICI. Senator Durenberger has told me that he has had an opportunity of talking to seniors who have opted for the experimental voucher system. We kind of implied that there was a very close relationship between the doctor and the doctor's clients. And you really want to go to a doctor because either you folks knew him or you started years ago. In my case, it was because Dr. Reidy finally delivered a boy. And so my father thought, well, he must be great. Excuse me. Dr. Reidy delivered all the girls and then Dr. Hannah was called in emergency. I was born in a farm-

house and my dad thought he obviously was better than Reidy. He had a son. So we had the doctor all our lives.

He tells me that the voucher system is causing people to change their way of doing business because it is simple. Is that right?

Senator DURENBERGER. Yes; there is no paperwork.

Chairman DOMENICI. So they make completely different choices.

Senator DURENBERGER. 30,000 people had the choice of 1 out of 4 competing different plans and it works well.

Chairman DOMENICI. I think that is something that we might have missed. But it probably is very onerous on the senior citizens to do the paperwork that is involved and go to the various offices and get all these various pieces of paper, and always indicated, try to make corrections. Your suggestions, the five of you made, were tremendous. Some of them we ought to do. We can't force cooperation. We can make sure that the "we's" and "they's" are on the same group when we appoint groups. I am most appreciative of you both waiting all day with your testimony.

Thank you very much.

Senator DURENBERGER. I think we are officially finished.

[Whereupon, at 3:41 p.m., the committee was adjourned, to reconvene subject to the call of the Chair.]

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